



CIGNA HealthCare

# Request to Amend Private Health Information

THIS FORM WILL ALLOW ME TO REQUEST AN AMENDMENT OF MY PRIVATE HEALTH INFORMATION (PHI) THAT CIGNA HEALTHCARE\* MAINTAINS.

## VERIFICATION – (Please Print)

**Identification of Member/Participant:** (The following information is needed for verification. Please complete all applicable items.)

Name of Member/Participant: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone number where we can reach you if we need to contact you to process your request (required): \_\_\_\_\_

Social Security #: \_\_\_\_\_ Group or Account # on ID card: \_\_\_\_\_

Member/Participant ID card # (if applicable): \_\_\_\_\_ Subscriber Name (if different from Member/Participant): \_\_\_\_\_

Subscriber's Relationship to Member/Participant: \_\_\_\_\_ Subscriber's Employer Name: \_\_\_\_\_

Subscriber's Social Security # (if different from Member/Participant): \_\_\_\_\_

## INFORMATION REQUESTED TO BE AMENDED

If CIGNA HealthCare was not the originator of the information you are requesting to amend, you should contact the originator directly to amend the information. For example, this would apply to your diagnosis, the date of service, or the treatment received. If the provider consents to amend your information and notifies CIGNA HealthCare, we will change the information in our records. In that case, it would not be necessary to submit this form.

If CIGNA HealthCare approves your request to amend, the amended information will be used and included in all future disclosures, including correspondence. We will provide the amendment to persons who previously received the information if we believe they have relied or will rely on that information to your detriment. Also, we will provide the amendment to individuals/organizations you identify below.

Names/addresses of individuals/organizations to whom you request amended information be sent, if request is approved:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe the Private Health Information (PHI) you would like amended: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Specify change/amendment requested: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date(s) of service associated with the PHI, if applicable: \_\_\_\_\_

Reason for requested amendment: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please Complete Form On Next Page ➡

**PLEASE NOTE**

- *This amendment of your private (protected) information **only includes information that CIGNA HealthCare and its affiliates maintains.** It does not include information that may be maintained by the subscriber’s employer/group health plan, their business associates, or other insurers of the group health plan that may administer your health care benefits. You should contact your employer or those entities to obtain additional information.*
- *If the information on this form is not complete, CIGNA HealthCare will return the form to you, and this request will not be considered until CIGNA HealthCare has received complete information.*

**SIGNATURE**

I have read and understand the above information:

Date: \_\_\_\_\_ Signature of Member/Participant, Parent/Guardian, Personal Representative: \_\_\_\_\_

Relationship if signed by other than Member/Participant: \_\_\_\_\_

**Note that if not already provided, we will require verification of the authority of a Personal Representative before this request will be considered complete.**

If Member/Participant is unable to give consent because of age, complete the following: Member/Participant is a minor \_\_\_\_\_ years of age.  
 If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

\*“CIGNA HealthCare” refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.

Please Return This Completed Form To:

CIGNA HEALTHCARE • PRIVACY OFFICE • PO BOX 55270 • PHOENIX AZ 85078-5270