STATEMENT OF DISAGREEMENT/ REQUEST TO FORWARD DENIAL OF AMENDMENT REQUEST

This form will allow me to provide a Statement of Disagreement to the Cigna Healthcare denial of my request to amend my Protected Health Information (PHI) that Cigna Healthcare maintains. I understand if I do not wish to submit a written Statement of Disagreement, I may still request that the Cigna Healthcare denial of my amendment request be forwarded.

VERIFICATION – (Please print)

Identification of customer:

(The following information is needed for verification. Please complete all applicable items.)

Name of customer: _____ Date of birth: _____

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

Current address on file: _____

_____

Medicare ID #: _____ Customer ID card # (if applicable): _____

- Submission of this form will not lead to the amendment of your information.
- 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 you received. If the originator provides consent 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.

PHI amendment request that was denied and is the subject of your statement of disagreement:

_____

Date of disputed PHI (if applicable): _____

STATEMENT OF DISAGREEMENT
(Complete if you wish to submit a Statement of Disagreement.)

Describe why you disagree with the denial to amend PHI (Please continue on a separate sheet of paper if necessary):

_____

_____

_____

_____

_____

Please complete the other side.

Cigna Healthcare will forward your request to amend your PHI, the Cigna Healthcare denial, this form, including any Statement of Disagreement, and any Cigna Healthcare rebuttal when sending correspondence containing the disputed information. We will not forward this information with correspondence to you.

☐ If you do not wish to submit a Statement of Disagreement, but would like your request to amend PHI and the Cigna Healthcare denial to be forwarded when Cigna Healthcare sends correspondence containing the disputed information, please check the box at the left.

PLEASE NOTE

- 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.
- If your date of birth or customer ID changes, a new form must be completed at that time.
- You may change or revoke this request by sending a written request to Cigna Healthcare at the address below. You can obtain a Change/Revoke form by calling Cigna Healthcare at the number on your Cigna Healthcare ID card.

SIGNATURE

I have read and understand the above information. Date: _____

Signature of customer, parent/guardian, other person legally authorized to act on behalf of the customer:

_____

Relationship, if signed by other than customer: _____

Note that, if not already provided, we will require verification of the authority of another person to act on behalf of the customer before this request will be considered complete.

If customer is unable to give consent because of age, complete the following:

Customer 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.

COMPLETED FORM MAILING ADDRESSES

Please send your completed form to your plan's corresponding address below:

Cigna Medicare Advantage Plan

Cigna Healthcare Privacy Office
PO Box 188014
Chattanooga, TN 37422

Cigna Medicare Prescription Drug Plan

Cigna Healthcare
PO Box 269005
Weston, FL 33326-9927

Please maintain a copy of this form for your records.

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