REQUEST FOR CONFIDENTIAL COMMUNICATIONS AND RESTRICTIONS REQUEST

This form will allow me, as a Cigna Healthcare℠ Customer, including Behavioral Health, to request to receive communications of Protected Health Information (PHI) about me by alternative means or at alternative locations and request a restriction on the use and disclosure of my PHI. **All fields marked with * are mandatory.**

*1. Verification – (Please Print)

Identification of Customer: (The following information is needed for verification. Please complete all applicable items.)

***Name of Customer:** _____ ***Date of Birth:** _____

***Address on Record (required):** _____

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

***Customer's Email Address:** _____

Last 4 Social Security # (optional): _____ ***Customer ID Card #:** _____

Group or Account # on ID Card: _____

Subscriber Name (if different from Customer): _____

If you have additional coverage with Cigna Healthcare, other than described above, please complete the following information as well:

Other Employer Name: _____

Customer ID Card #: _____ **Group or Account # on ID Card:** _____

2. Confidential Communications Request

I request to receive communications of my PHI from Cigna Healthcare:

☐ By alternate means or location (please describe and provide address): _____

*3. Restrictions Request (only complete if requesting a restriction)

☐ Please describe your request:

_____

_____

Please indicate below if you wish the following access restriction to apply:

☐ I wish to deny other family members covered under my policy access to my PHI via phone and Internet. If you make this election and you are not the Subscriber, you will not be able to access your information on the Internet. You will need to call the number on your or the Subscriber's ID card to obtain information by phone. (The Subscriber will still be able to obtain his/her own PHI via phone and Internet.) Important: If you wish to implement this type of restriction, you must complete the verification question section on page 2.

☐ I do not want Cigna Healthcare to share information about services I receive from one health care professional or facility (HCP/HCF) with another HCP or HCF for the purpose of participating in a Cigna Collaborative Care arrangement. For information on collaborative care, you may contact Cigna Healthcare Customer Service.

THE Cigna GROUP

Verification Questions – (This section applies only to requests for access restrictions.)

The answers you provide below will be used to verify your identity if you call for your protected health information. Note that we ask these questions because the answers should be easy for you to remember, but you may enter other numbers as described below.

4-digit PIN (you may use any 4-digit number): _____

What is your mother's date of birth?: (answer in the following 8-digit format: 11231949 for November 23, 1949) _____ You may use any date, however, it cannot be a future date, and it must be a legitimate calendar date.

For example, we cannot accept 11361949 (November 36, 1949) because there are not 36 days in November. We also cannot accept 11232030 (November 23, 2030) because 2030 is a future date.

- Please DO NOT provide anyone else with the answers to these questions.
- You should keep a copy of this form for reference.

Please Note

- If you are not the Subscriber, any check payment for services you receive that is not sent to the health provider will be sent to the Subscriber. Therefore, a Subscriber may receive a check that may prompt questions to you about the services rendered.
- Communications containing your PHI will be sent to the address you have provided on this form.
- If the information on this form is not complete, Cigna Healthcare will return the form to you, and this request may not be considered until Cigna Healthcare receives complete information.
- If either the Customer or Group changes to a different type of health care benefits coverage provided by Cigna Healthcare, another form will need to be completed at that time.
- You may change or revoke this request by sending a written request to Cigna Healthcare, Central HIPAA Unit, at the address at the end of this form. If you wish to change or revoke this request you must provide the updated address that you wish to use going forward.

*4. Signature

I have read and understand the above information: (Print name) _____ Date: _____

Signature of Customer, Parent/Guardian, Personal Representative if available: _____

Relationship if signed by other than Customer: _____

Note that if not already provided, we will require verification of the authority of a Personal Representative before this request will be considered complete, including furnishing a copy of the health care power of attorney or other relevant document.

If 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.

Please Return This Completed Form:

Fax to: 877.815.4827 or 859.410.2419

or

Mail to: Cigna Healthcare Central HIPAA Unit,
PO Box 188014,
Chattanooga, TN 37422.