



CIGNA Behavioral Health

Request for Confidential Communications

THIS FORM WILL ALLOW ME, AS A CIGNA BEHAVIORAL HEALTH* MEMBER/PARTICIPANT TO REQUEST TO RECEIVE COMMUNICATIONS OF PRIVATE HEALTH INFORMATION (PHI) ABOUT ME BY ALTERNATIVE MEANS OR AT ALTERNATIVE LOCATIONS.

If a request is made for an alternate location, I understand correspondence will continue to be addressed to me, but will be mailed to the address I provide below. I understand all Member/Participant correspondence to me will be mailed to this alternate address whether or not it contains any confidential information about me. I understand that this request may be denied if it cannot reasonably be accommodated.

Note: If your request is granted, it will affect only written and oral communications by CIGNA Behavioral Health. If you also wish your employer, group health plan, physician or anyone outside of CIGNA Behavioral Health to make this change, you must obtain their agreement separately.

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 #: _____ Member/Participant ID card # (if applicable): _____

Group or Account # on ID card: _____ 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): _____

If you have additional coverage with CIGNA Behavioral Health, other than that which is described above, please complete the following information as well:

Other Employer Name: _____

Member/Participant ID card #: _____ Group or Account # on ID card: _____

Does this request apply to all coverage? Yes No

REQUEST

1. I request to receive communications of my PHI from CIGNA Behavioral Health:

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

Please Note: If you are requesting only phone or e-mail communications, we may not be able to provide you with all required communications in that format and may need to deny your request.

Reason why the alternate means or location is necessary: _____

2. Restriction request: (Please indicate by checking the item below.)

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.)

Please Complete Form On Next Page ➡

CIGNA Behavioral Health will not disclose confidential information without your authorization unless it is necessary to provide your health benefits, administer your benefit plan, to support CIGNA Behavioral Health programs or services, or as otherwise required or permitted by law. We will not, for example, give your confidential information to a credit agency, a telemarketer or a prospective employer. We will not sell, rent or license the confidential information you provide to us. You do not need to request a restriction if you are concerned about those uses and disclosures.

VERIFICATION QUESTIONS (Required for Request #2 only.)

The answers you provide will be used to verify your identity if you call for your PHI. You must answer these questions if you checked box #2 in the Request section above. 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.

Last 4 digits of your favorite credit card (you may use any four 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 11232010 (November 23, 2010) because 2010 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. Additionally, if the Subscriber has enrolled in either an FSA or Health Spending Account (HSA) plan, he/she will be able to obtain information (i.e., date of service, amount of claim) on claims incurred under his/her health benefit plan.*
- *If the Subscriber is enrolled in a Flexible Spending Account (FSA), Health Reimbursement Arrangement (HRA), or Health Savings Account (HSA), he/she will also receive an EOB for any claim submitted for reimbursement. In many cases, claims submitted for payment by the Subscriber's health benefit plan will be automatically submitted to his/her FSA or HSA for reimbursement.*
- *Communications containing your PHI will to be sent to the address you have provided on this form.*
- *If an alternate address is approved, it may be shown on correspondence about you that CIGNA Behavioral Health sends to others, such as your provider.*
- *If the information on this form is not complete, CIGNA Behavioral Health will return the form to you, and this request may not be considered until CIGNA Behavioral Health receives complete information.*
- *If your Member/Participant ID or date of birth is changed, another form will need to be completed at that time.*
- *If either the Member/Participant or Group changes to a different type of health care benefits coverage provided by CIGNA Behavioral Health, another form will need to be completed at that time.*
- *You may change or revoke this request by sending a written request to CIGNA Behavioral Health, Central HIPAA Unit, at the address on page 3. You can obtain a Change/Revoke form by calling CIGNA Behavioral Health Member Services at 1.800.926.2273.*

Please Complete Form On Next Page ➡

SIGNATURE AND NOTARIZATION

To safeguard your privacy and help make sure no one else is requesting access to your PHI, this request must be notarized. *(Notary services can often be provided free at a bank where you have an account).*

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.		
State of)	
) ss.	
County of)	
On this the _____ day of _____, 20____, before me, _____ (Notary Public), the undersigned officer, personally appeared _____ (member or legal rep. name), known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument and acknowledges that (s)he executed the same for the purposes therein contained.		
In witness whereof I hereunto set my hand.		
_____ Notary Public		
My Commission expires: _____		

***"CIGNA Behavioral Health" refers to CIGNA Behavioral Health, Inc. and subsidiaries of CIGNA Behavioral Health, Inc., including CIGNA Behavioral Health of California, Inc.*

TO RETURN YOUR COMPLETED FORM

Mail to: CIGNA Behavioral Health Central HIPAA Unit, 11095 Viking Drive, Ste. 350, Eden Prairie, MN 55344