



CIGNA HealthCare

Change/Revoke Request

THIS FORM WILL ALLOW ME, AS A CIGNA HEALTHCARE* MEMBER/PARTICIPANT, TO REQUEST A CHANGE OR REVOCATION TO A PREVIOUSLY-APPROVED REQUEST FOR RESTRICTION, CONFIDENTIAL COMMUNICATIONS, PERSONAL REPRESENTATIVE, AUTHORIZATION, OR STATEMENT OF DISAGREEMENT. I UNDERSTAND BY COMPLETING AND SIGNING THIS FORM, I AUTHORIZE CIGNA HEALTHCARE TO CHANGE OR REVOKE A PREVIOUSLY-APPROVED REQUEST.

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, other than described above, please complete the following information as well:

Other Employer Name: _____

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

RESTRICTION

Please complete this section ONLY if you have an active privacy restriction on file with CIGNA HealthCare.

1. I wish to revoke my restriction to deny other family Members/Participants covered under my policy access to my Personal Health Information (PHI) via phone and internet.
2. I wish to revoke all other restrictions. Please describe the specific restriction request you wish to revoke: _____

3. I wish to change the answers to my verification questions:

If you checked box 3 above, you must provide the updated answers that you wish to use going forward:

- 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.

- What are the last 4 digits of your favorite credit card (you may use any four digit number): _____

CONFIDENTIAL COMMUNICATIONS

Please complete this section ONLY if you have an active confidential communications address on file with CIGNA HealthCare.

1. I wish to revoke my confidential communications address.
2. I wish to change my confidential communications address.

If you checked box 2 above, you must provide the updated address that you wish to use going forward: _____

Please Complete Next Page ➡

PERSONAL REPRESENTATIVE

Please complete this section ONLY if you have an active Personal Representative on file with CIGNA HealthCare.

1. I wish to revoke my Personal Representative.
2. I wish to change my Personal Representative information. Please check what you want to change and provide the updated information in the space provided:
 - 2a. Personal Representative's name: _____
 - 2b. Personal Representative's address: _____
 - 2c. Personal Representative's Date of Birth (answer in the following 8-digit format: 11231949 for November 23, 1949):

 - 2d. Personal Representative's verification questions:

If you checked box 2d above, you must provide the updated answers that you wish to use going forward:

- 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.

- What are the last 4 digits of your favorite credit card (you may use any four digit number): _____

PRIVACY AUTHORIZATION REQUEST

Please complete this section ONLY if you have an active privacy authorization on file with CIGNA HealthCare.

- I wish to revoke my Privacy Authorization.
- Name of the Individual(s) or Company(ies) that are no longer authorized to receive my PHI: _____
 - Specific information that the above-revoked Authorization allowed (e.g., claims status, medical information, eligibility): _____

STATEMENT OF DISAGREEMENT

Please complete this section ONLY if you previously submitted either a Statement of Disagreement or a request to forward information related to a denial of your request to amend PHI.

- I wish to revoke my request to have some or all of the following information forwarded when CIGNA HealthCare sends correspondence concerning the disputed information: my request to amend PHI, the CIGNA HealthCare denial, any Statement of Disagreement, and any CIGNA HealthCare rebuttal.

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 receives complete information.
- If any enrollment information such as Social Security Number (SSN), 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 Subscriber changes health care benefits coverage within CIGNA HealthCare, another form will need to be completed at that time.

Please Complete Next Page ➡

