



CIGNA Behavioral Health

Request for Restriction of Use and Disclosure of Private Health Information

THIS FORM WILL ALLOW ME, AS A CIGNA BEHAVIORAL HEALTH* MEMBER/PARTICIPANT, TO REQUEST A RESTRICTION ON THE USE AND DISCLOSURE OF MY PRIVATE HEALTH INFORMATION (PHI). I UNDERSTAND CIGNA BEHAVIORAL HEALTH WILL CONSIDER ALL REQUESTS FOR RESTRICTIONS CAREFULLY; HOWEVER CIGNA BEHAVIORAL HEALTH IS NOT REQUIRED TO AGREE TO A REQUESTED RESTRICTION.

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

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.

REQUESTED RESTRICTIONS

Please describe your request: _____

Please Indicate Below If You Wish the Following 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.)

If you wish to implement this type of restriction, you must complete the Verification Questions below.

VERIFICATION QUESTIONS

The answers you provide below will be used to verify your identity if you call for your private 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 on the following page.

Please Complete Form On Next Page ➡

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.

- I do not wish to be contacted for the programs offered by CIGNA, its agents or subsidiaries as specified on this form except where required for administration of the benefit plan, by law or in direct response to my request or inquiry.** Important: Even if you choose this restriction, CIGNA must still contact you with specific information related to your benefit plan or where required by law.
- Global Opt Out** – I elect not to receive any phone or written contact from CIGNA HealthCare medical, vision, pharmacy, behavioral health and dental programs except where it is required for administration of the benefit plan or by law.
- E-Mail** – I elect not to receive e-mail correspondence.
- Surveys** – I elect not to receive surveys for any reason, except where required for the administration of the benefit plan or by law or in direct response to my request or inquiry.
- Printed Materials** – I elect not to receive printed materials, including educational materials, brochures and newsletters, except where required for administration of the benefit plan, by law or in direct response to my request or inquiry.
- Letters and Correspondence** – I elect not to receive any letter or correspondence except where required for administration of the benefit plan, by law or in direct response to my request or inquiry. This includes routine preventive health reminders.
- Phone Calls** – I elect not to receive any phone calls, except where required for the administration of the benefit plan and or by law or in direct response to my request or inquiry.

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.*
- *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. 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.*
- *Communications, including communications containing PHI, will continue to be sent to the current address we have on file for you.*
- *If any information on this form is not complete, CIGNA Behavioral Health will return the form to you, and your restriction request will 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 restriction by sending a written request to CIGNA Behavioral Health, Central HIPAA Unit, at the address shown below.*
- *You can obtain a Change/Revoke form by calling CIGNA Behavioral Health Member Services at 1.800.926.2273.*

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: If not already provided, we will require verification of the authority of a Personal Representative before this request will be considered complete.

If request is made by a Parent/Guardian, complete the following: Member/Participant is a minor ____ years of age.

If you are a parent or guardian requesting a restriction on a child that will prevent the child's other legal parent from accessing the child's private health information, you must:

1. provide evidence that the parental rights of the other parent have been terminated, or
2. obtain the other parent's agreement to this restriction. If you obtain the other parent's agreement to this restriction, please have the other parent sign this form and notarize it, or send a statement signed and notarized by both parents indicating that both parents have agreed to place a restriction on the child's private health information.

TO RETURN YOUR COMPLETED FORM

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

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

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