



CIGNA Behavioral Health

Statement of Disagreement/Request to Forward Denial of Amendment Request

THIS FORM WILL ALLOW ME TO PROVIDE A STATEMENT OF DISAGREEMENT TO THE CIGNA BEHAVIORAL HEALTH* DENIAL OF MY REQUEST TO AMEND MY PRIVATE HEALTH INFORMATION (PHI) THAT CIGNA BEHAVIORAL HEALTH MAINTAINS. I UNDERSTAND IF I DO NOT WISH TO SUBMIT A WRITTEN STATEMENT OF DISAGREEMENT, I MAY STILL REQUEST THAT THE CIGNA BEHAVIORAL HEALTH DENIAL OF MY AMENDMENT REQUEST BE FORWARDED.

PLEASE NOTE: If you complete this form and your or the Subscriber's employer benefit plan receives reports that contain your disputed PHI, we are required by law to forward to your or the Subscriber's employer your request to amend PHI, the CIGNA Behavioral Health denial, this form, including any Statement of Disagreement, and any CIGNA Behavioral Health rebuttal.

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 described above, please complete the following information as well:

Other Employer Name: _____

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

- *Submission of this form will not lead to the amendment of your information.*
- *If CIGNA Behavioral Health 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 provider consents to amend your information and notifies CIGNA Behavioral Health, 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 second page if necessary): _____

Please Complete Form On Next Page ➡

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

- If you do not wish to submit a Statement of Disagreement, but would like your request to amend PHI and the CIGNA Behavioral Health denial to be forwarded when CIGNA Behavioral Health 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 Behavioral Health will return the form to you, and this request will not be considered until CIGNA Behavioral Health has received 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 below. You can obtain a Change/Revoke form by calling CIGNA Behavioral Health Member Services at the number on your CIGNA Behavioral Health ID card.*

SIGNATURE

I have read and understand the above information:	Date: _____
Signature of Member/Participant, Parent/Guardian, if available: _____	
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.	

*"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