CIGNA Medicare Rx® (PDP)
Medicare Part D Prescription Drug Plans

Change/Revoke Request

This form will allow me, as a CIGNA Medicare Rx* Member, 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 Medicare Services℠ to change or revoke a previously-approved request.

VERIFICATION – (Please Print)

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

Name of Member: _____ Date of Birth: _____

Address: _____

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

_____

Medicare ID #: _____ Member ID card # (if applicable): _____

RESTRICTION

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

1. ✷ I wish to revoke my restriction. Please describe the specific restriction request you wish to revoke:

   _____

2. ✷ I wish to change the answers to my verification questions:

   If you checked box 2 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): ___ ___ ___ ___.

Please Complete Next Page

CONFIDENTIAL COMMUNICATIONS

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

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: _____

   _____

   _____

PERSONAL REPRESENTATIVE

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

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 are the 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.

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PRIVACY AUTHORIZATION REQUEST

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

✷ I wish to revoke my Privacy Authorization.

- Name of the Individual(s) or Company(ies) that are no longer authorized to receive my Private Health Information (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 Medicare Services sends correspondence concerning the disputed information: my request to amend PHI, the CIGNA Medicare Services denial, any Statement of Disagreement, and any CIGNA Medicare Services rebuttal.

PLEASE NOTE

- If the information on this form is not complete CIGNA Medicare Services will return the form to you, and this request will not be considered until CIGNA Medicare Services receives complete information.
- If your date of birth or Member ID changes, a new form will need to be completed at that time.

SIGNATURE AND NOTARIZATION

If your request is regarding a Restriction, Privacy Authorization, or Statement of Disagreement, please complete the signature section labeled A. If your request is regarding a Personal Representative or Confidential Communications, please complete the signature and notarization section labeled B.

A. SIGNATURE

I have read and understand the above information. Date: _____

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

Relationship if signed by other than Member: _____

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 request is made by a Parent/Guardian, complete the following: Member 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 Complete Next Page

B. SIGNATURE AND NOTARIZATION

I have read and understand the above information. Date: _____

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

_____

Relationship if signed by other than Member: _____

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 request is made by a Parent/Guardian, complete the following: Member 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: _____

Please maintain a copy of this form for your records.

Please Return This Completed Form To:

CIGNA Medicare Services • PO Box 269005 • Weston, FL 33326-9927