Request for Diagnosis and Treatment Code Information

You are encouraged to contact your Health Care Professional as the person responsible for providing Cigna with this information for their interpretation of this information and its relevance to your health.

Use this form to ask for more information about diagnosis and treatment codes used to bill Cigna for health services you - or someone else covered under your plan - received. Be sure to:

- Provide all the information requested
- Print your answers so they are readable
- Send the completed and signed form to:

Correspondence Unit
Cigna Global Health Benefits[SM]
P.O. Box 15050
Wilmington, DE 19850
or Fax: 302-797-3150

If you are a registered customer on the Cigna Global Health Benefits website, Cigna Envoy, you may send the completed form via secure email through www.Cignaenvoy.com.

INFORMATION ABOUT YOU:

The information you want is "protected health information." This means we will share it only with those who are authorized to see it. The information you give us below lets us verify that you are a Cigna customer and look up the information you need.

Customer Name: *(First)* *(M.I.)* *(Last)*

Customer Date of Birth: (MM/DD/YYYY)	Telephone Number where we can reach you if we need to contact you to process your request:	Best Time to Reach You:

E-Mail Address:	Customer ID Card No. *(if applicable)*:	Group or Account No. on ID card:

Subscriber Name: *(if different from Customer)*	Subscriber's Relationship to Customer:

Subscriber's Employer Name:

YOUR REQUEST:

Check the box(es) next to the information you want. Provide the name of the health care professional(s), their address(es) and the date(s) of the service or treatment. If available, list the Claim Number(s) found on your Explanation of Benefits (EOB). Please note that this information is generally available only for one year (12 months) after the date of the service or treatment. We may be able to retrieve older information in our archived files, but that will take additional time.

☐ Diagnosis Codes *(and their standard definitions)* ☐ Treatment Codes *(and their standard definitions)*

Health Care Professional(s) who provided the service or treatment		**Date(s) of Service**		**Claim No.**
Name(s)	Address(es)	First date of treatment	Last date of treatment	

Clear Form

UNDERSTANDING YOUR TREATMENT AND DIAGNOSIS CODES:

The information provided will include standardized definitions of treatment and diagnosis codes from sources such as the International Classification of Disease (ICD) Manual and Current Procedural Terminology (CPT) coding references.

IMPORTANT INFORMATION: BEFORE YOU SIGN AND SEND THIS FORM

Be sure you have given us all the information required. If the information on this form is not complete, Cigna will return the form to you and this request will not be considered until we receive a complete form.

YOUR SIGNATURE:

I have read and understand the above information:

Signature of Customer, Parent/Guardian, Personal Representative *(if applicable)*: Date: (MM/DD/YYYY)

_____ _____

Relationship *(if signed by other than Customer)*:

_____

Please 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:

Customer 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.