MEDICAL MUTUAL®

Request to Access Protected Health Information

I am requesting access to my protected health information that Medical Mutual maintains in a designated record set.

Please note: Items marked with an asterisk (*) are required.

Member Information			
Last Name*	First Name*	MI	Birthdate
Group Number	Member ID Number*		

Request Information

Please check the category of protected health information you want sent to you:

☐ Eligibility ☐ Claims ☐ Customer Service ☐ Medical

If you are requesting a record related to a phone call to Customer Service, include the date and time you called in the below. If you are requesting information about a specific claim, include the claim number, date of service and name of the doctor or hospital in the space below.

Signature*

Signature	Date

If you are an authorized representative, please sign below and enclose supporting documentation as required by state law (such as power of attorney, estate documentation or guardianship papers).

Signature of Authorized Representative	Relationship	Date

Please complete all sections above. Send the signed and completed form to:

Medical Mutual
P.O. Box 89499
Cleveland, OH 44101-6499

Medical Mutual will review your request and notify you in writing of our decision.

For more information, see the Notice of Privacy Practices at MedMutual.com, or call the Customer Care number on your member identification card to request a copy.