MEDICAL MUTUAL®

Violation of Confidentiality or Privacy Complaint Form

I wish to file a complaint about a violation of my guaranteed privacy and confidentiality rights with Medical Mutual. I understand Medical Mutual will not retaliate against me and my benefits will not be impacted in any way for submitting this complaint.

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

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

Explanation for Complaint*
Please describe the circumstances of your complaint in detail, including dates, parties involved and the alleged violation.

Signature*	
Member 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 contact you with a response after we investigate your complaint.

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.