MEDICAL MUTUAL®
CAROLINA CARE PLAN | CONSUMERS LIFE

(OPS)
P.O. Box 89499
Cleveland, OH 44101-6499

CORRECT / AMEND INFORMATION REQUEST

PRIVACY & CONFIDENTIALITY REQUEST FORM

Please complete all sections of this form.

I am requesting change to the health information stored by Medical Mutual to correct an error or add information that has been left out of my record. I understand that information submitted by a medical doctor or health facility will need to be corrected by them.

Your General Information: * *Required Information*		
Last Name: *	First Name: *	M.I.
Medical Mutual ID Number: *	Birth Date (MM/DD/YY):	
Group Number: *		

Request Information:

To request an amendment to correct an error or add information omitted from your personal health information:

Attach a copy of the record you are requesting to be amended or corrected, and include an explanation supporting your request to correct or add information.

Closing:

Signature: *	Date: *

For more information, refer to the Medical Mutual Privacy Notice located at MedMutual.com, or to receive a copy, call the Customer Service telephone number on your identification card.

Send completed and signed form to:

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