



MEDICAL MUTUAL OF OHIO.
Your healthcare partner since 1934

CONFIDENTIAL COMMUNICATIONS FORM
PRIVACY & CONFIDENTIALITY REQUEST FORM

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

Please complete all sections of this form.

I am requesting that all communications regarding my personal health information be kept confidential, and are sent to a different address. All future communications should be sent to the address I have listed below.

Your General Information \*required information

Last Name\*:
First Name\*: Middle Initial:
Medical Mutual ID Number\*: Birth Date (MM/DD/YY):
Group Number\*:

Request for Confidential Communication – Designating Different Address

Please fill in the location to where your communications are to be sent. Note: Medical Mutual will send a letter to you at this new address to confirm that your request has been processed.

Street\*:
City\*: State\*: Zip Code\*:

Reason for Request\*:
[Blank lines for text entry]

Age Requirements: Requestor must be age 18 or greater unless requestor qualifies to receive medical care or treatment without prior parental consent under applicable state law.

Your 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 the back of your identification card.

Send completed and signed form to: Medical Mutual
P.O. Box 89499
Cleveland, Ohio 44101-6499