MEDICAL MUTUAL OF OHIO®
Your healthcare partner since 1934

CORRECT / AMEND INFORMATION REQUEST

(OPS)

PRIVACY & CONFIDENTIALITY REQUEST FORM

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

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.

General Information ***required information**

Last Name*: ______________________________

First Name*: ______________________________ Middle Initial: ____

Medical Mutual ID Number*: ____________________ Birth Date (MM/DD/YY): _____/_____/______

Group Number*: ______________________________

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.

* ____

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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