



MEDICAL MUTUAL OF OHIO.
Your healthcare partner since 1934

REQUEST FOR RECORD SET

PRIVACY & CONFIDENTIALITY REQUEST FORM

(OPS)

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

Please complete all sections of this form.

I am requesting a listing of my personal health information that is stored by Medical Mutual. This is commonly known as a "designated record set."

General Information

*required information

Last Name*: _____

First Name*: _____ Middle Initial: _____

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

Group Number*: _____

To request a copy of your personal health information in a designated record set:

Please check the category of personal 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 space 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.

Four horizontal lines for providing additional information.

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