MEDICAL MUTUAL®

Request for an Amendment of Protected Health Information

I am requesting a change to my protected health information stored by Medical Mutual to correct an error or add information that has been left out of my record. I understand information submitted by a healthcare provider or another third party will need to be corrected or added by them.

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

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

Explanation for Request*

To request a change to correct an error or add information to your protected health information that is maintained by Medical Mutual in a designated record set. Attach a copy of the record you are requesting to be amended or corrected. Include an explanation supporting your request to correct or add information.

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 review your request and notify you in writing of our decision.

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.