MEDICAL MUTUAL®

Confidential Communications Request Form

I am requesting that my Explanation of Benefits statements (EOBs) are sent to a different address, which I have listed below.

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

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

Request Information (Please fill in the address where your communications should be sent.)			
Medical Mutual will send you a letter at this address to confirm your request has been processed.			
Last Name	First Name		
Street Address*	City*	State*	ZIP Code*
Primary Phone Number / Secondary Phone Number	Email Address		
Reason for Request*			

Age Requirements: You must be 18 or older unless you qualify to receive medical care or treatment without prior parental consent under applicable state law. Individuals under age 18 should provide evidence of their ability to access medical care or treatment without the consent of a parent or supervising adult.

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

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.