MEDICAL MUTUAL®
CAROLINA CARE PLAN | CONSUMERS LIFE

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

REQUEST FOR RECORD SET

PRIVACY & CONFIDENTIALITY REQUEST FORM

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. "

Your General Information: * *Required Information*	
Last Name: *	First Name: * M.I.
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.

Closing:

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 your identification card.

Send completed and signed form to:

Medical Mutual of Ohio
P.O. Box 89499
Cleveland, Ohio 44101-6499