MEDICAL MUTUAL®

Free of Care Form

Reset Fields

Your Medical Mutual healthcare plan contains a Free of Care provision. Free of Care is the term used by Medical Mutual to identify if the illness or condition on a claim has been previously treated. In order to finalize the claim with Medical Mutual, please supply the required information below. A response within ten (10) days would be appreciated. Please send the completed form to: **Medical Mutual, P.O. Box 956, Toledo, Ohio, 43697**. Thank you for your response to our claims inquiry.

Patient Information (The first 7 items can be found in the letter you received.)			
Patient Name			
Provider			
Claim Number	**Certificate Number**	**Date of Service**	**Patient Account Number**
Date of Payment	**Was the patient previously treated for any condition reported on this claim?** ☐ **Yes** ☐ **No**		
If "Yes" is selected, at least one Diagnosis and Date of Treatment must be entered.			

Diagnosis	Date of Treatment	Date of Prescription
Signature		**Date**

Send completed and signed form to:	**Or fax to:**
Medical Mutual P.O. Box 956 Toledo, Ohio 43697	