MEDICAL MUTUAL®

Revocation of Confidential Communications Request Form

Please revoke my previous request to have my Explanation of Benefits statements (EOBs) sent to an alternate address. Completing this revocation form means that my EOBs will now be sent to my plan mailing address.

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

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

Explanation for Revocation*

Please explain your request and the full address you are revoking. (Note: The revocation will not apply to information released prior to Medical Mutual's receipt of this revocation form.)

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.