CONFIDENTIAL COMMUNICATIONS FORM

PRIVACY & CONFIDENTIALITY REQUEST FORM

InHealth Mutual
501 West Schrock Road
Suite 310
Westerville, Ohio 43081

Please complete all sections of this form.

I am requesting that my Explanation of Benefit statements (EOBs) are sent to a different address. All EOBs should be sent to the address I have listed below.

Your General Information: * Required Information

Last Name: *	First Name: * M.I.
InHealth Mutual ID Number: *	Birth Date (MM/DD/YY):
Group Number: *	

Request for Confidential Communication – Designing Different Address:

Please fill in the location where your communications should be sent. Note: InHealth Mutual will send a letter to you at this address to confirm that your request has been processed.

Street Number: *		
City: *	State: *	Zip: *
Reason for Request: *		

Age Requirements: You must be age 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. Individuals under age 15 cannot receive confidential communication.

Closing:

Your Signature: *	Date: *

For more information, refer to the InHealth Mutual Privacy Notice located at inhealthohio.org, or to receive a copy, call the Customer Service telephone number on your identification card.

Send completed and signed form to:

InHealth Mutual
Attn: Privacy Officer
501 West Schrock Road
Suite 310
Westerville, Ohio 43081