REQUEST FOR RECORD SET

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 a listing of my personal health information that is stored by InHealth Mutual. This is commonly known as a "designated record set. "

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