How we share information with your providers

One of the unique features of an accountable care organization (ACO) plan is how Medica works with your provider to coordinate your health care. By sharing member information with each other, Medica and your ACO can help you get the care you need and deliver programs and services to help you get and stay healthy.

Medica and your ACO will share information about health services you receive from providers in the ACO network as well as providers outside the ACO network. The sharing excludes alcohol and drug abuse treatment records. Information sharing will occur automatically – you don’t need to take any action. You can, however, choose NOT to have your information shared by completing this form or calling Medica Customer Service at the number on the back of your ID card or 952-945-8000 or 800-952-3455. Please note you will continue to receive communications directly from Medica or your ACO providers regarding the management of your care. This form only pertains to information sharing between Medica and your ACO providers.

Only complete the following if you do NOT want Medica and your ACO to share your information with each other.

Please note:

- If you are the plan subscriber (the person enrolled in the plan through your employer), your decision applies to yourself and any dependents under age 13.
- Covered family members age 13 or older who don’t want their information shared between Medica and the ACO should each provide their information and sign below.
- Your signature is valid for 12 months from the date you sign this form.

Plan Information
ACO (plan) name:______________________________________________________________
Employer name:_________________________________________________________________
Group or policy number* (if known):_____________________________________________
Nine-digit Medica ID number* (if known):__________________________________________

*This number appears on the front of your Medica ID card.

Continued on reverse
Member #1
By signing below, I indicate I do NOT want my information shared between Medica and my ACO.

Member #1’s name (First and Last) please print: ________________________________

Member #1’s date of birth: ________________________________________________

Member #1’s email address: ________________________________________________

Member #1’s signature: ____________________________________________________

Date: __________________

Member #2
By signing below, I indicate I do NOT want my information shared between Medica and my ACO.

Member #2’s name (First and Last) please print: ________________________________

Member #2’s date of birth: ________________________________________________

Member #2’s email address: ________________________________________________

Member #2’s signature: ____________________________________________________

Date: __________________

Member #3
By signing below, I indicate I do NOT want my information shared between Medica and my ACO.

Member #3’s name (First and Last) please print: ________________________________

Member #3’s date of birth: ________________________________________________

Member #3’s email address: ________________________________________________

Member #3’s signature: ____________________________________________________

Date: __________________

If you need more space, please use another piece of paper to provide additional information for each member.

Please note: Your signature is valid for 12 months from the date you sign this form.

Return to:
Medica
PO Box 9310, CP 217
Minneapolis, MN 55440-9310

COM17242-1-00919
**Discrimination is Against the Law**

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability or sex. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - TTY communication and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters and information written in other languages.

If you need these services, call the number included in this document or on the back of your Medica ID card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.


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**If you want free help translating this document, call 1-800-952-3455.**

Si desea recibir asistencia gratuita para la traducción de este documento, llame al 1-800-952-3455.

Yog koj xav tau key pab dawb bzhais daim ntawv no, hrua 1-800-952-3455.

如果您需要我們免費幫您翻譯此文件，請致電 1-800-952-3455。

Nếu quý vị muốn giúp dịch tài liệu này miễn phí, gọi 1-800-952-3455.

Sanadnikun kaffaltimalaanikaisiniifhihamuyooobaaddan 1-800-952-3455 tinhibibiliaa.

إذا كنت ترغب في مساعدة مجانية لترجمة هذا المستند.

如果您想获得免费的翻译服务，请拨打1-800-952-3455。

Ako želite besplatnu pomoć za prijevod ovog dokumenta, nazovite 1-800-952-3455.

Wenn Sie kostenlose Hilfe zur Übersetzung dieses Dokuments wünschen, rufen Sie 1-800-952-3455 an.