PO Box 9310
Minneapolis, MN 55440-9310

MEDICA®

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.

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 12.
- Covered family members age 12 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):_____

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: _____

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

Continued on reverse

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: _____

Member #4
By signing below, I indicate I do NOT want my information shared between Medica and my ACO.

Member #4's name (First and Last) *please print*: _____

Member #4's date of birth: _____

Member #4's email address: _____

Member #4'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