

MPIHP Eligibility Department - Confidential  
MPI Health Plan  
P.O. 1999  
Studio City, CA 91614-0999

To whom it may concern,

I understand that I may lose my health coverage.

Pursuant to HIPAA, I hereby request that you issue me a Certificate of Credible Coverage as soon as possible.

Please mail the Certificate to me at my home address:

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sincerely,

Member's Name \_\_\_\_\_

Member's Signature \_\_\_\_\_