Date

Insurance Plan Name

Insurance Plan Address

To whom it may concern,

I am writing to request that the Summary of Payment (SOP) and any other communication about my visit on (date) at Planned Parenthood League of Massachusetts for sensitive services be suppressed from the subscriber of my insurance plan as dictated by the Massachusetts Division of Insurance in *Bulletin 2017-02; Common Summary of Payments Format.*

Patient Name:

Patient ID Number:

Please contact me by phone immediately if any additional information is needed to fulfill this request.

Sincerely,

(Signature)

(Patient name)

(Patient contact number)