Memorial Hermann Health Plan

Provider Request for Participation

Please complete all fields in the form below, then email along with a current W-9 to providerservices@memorialhermann.org.
You may also fax your completed form and W-9 to 713.338.4102.

Provider's First Name _____

Provider's Last Name _____

Facility Full Name_____

Group Name_____

Service Address_____

City/State_____

Zip Code_____

Phone_____

Fax_____

Email Address_____

Contact Name/Phone_____

Primary Hospital_____

Other Hospital Privileges_____

Doing Business As (DBA) _____

Mailing Address (if different)_____

City/State_____

Zip Code_____

TAX ID # (Attach w-9)_____

CAQH Number_____

NPI Number_____

Specialty_____

Sub Specialty_____

Services (please list below):

Active admitting privileges at a network hospital
along with an active unrestricted license are required for participation.

MEMORIAL HERMANN Health Plan