Request for Network Participation

MEMORIAL HERMANN Health Plan

Please complete all of the following fields. Your name must appear on this form as it does on your state professional license (if applicable). Please return this application request form to **MHHPContractingRFP@memorialhermann.org**. Date: _____

PRACTITIONERS

Last Name	First Name	M/I	Suffix	Professional Degree

Other Name	Date of Birth	Individual NPI #	CAQH ID #	Texas Professional License

Office Contact Name	Office Contact Phone Number	Office Contact Email	Check only one of the following
			☐ PCP ☐ Specialist ☐ Hospital Based

Primary Specialty	Subspecialty

Group Name/Practice Name

Group Tax ID #	Group NPI #	Office Phone Number	Office Fax Number

Primary Office Address	Suite	City	State	Zip Code

ANCILLARY SERVICES & FACILITIES

Facility Full Name	Doing Business As (DBA)	Facility Tax ID #	Facility NPI #

CAQH ID #	Office Phone Number	Office Fax Number	Email Address *(Office Manager/Administrator)*

Primary Office/Service Address	Suite	City	State	Zip Code

Contact Name	Contact Phone Number	Contact Email Address

Services	Primary Specialty	Subspecialty

CREDENTIALING CONTACT INFORMATION

Credentialing Contact Name	Credentialing Contact Email Address	Credentialing Contact Phone Number