

# Provider Data Update Notification Form

If requesting termination from a provider network, please contact  
Provider Relations at [providerservices@memorialhermann.org](mailto:providerservices@memorialhermann.org)

Name of provider/group\*: \_\_\_\_\_

NPI Number\*: \_\_\_\_\_  Type 1  Type 2

Tax ID Number: \_\_\_\_\_

Please select all categories that apply and attach applicable documentation:

- Name Change
  - Note: If this change is for a Group, attach signed and dated W9
- Office Address/Telephone/Fax Change
  - Note: If your primary address change involves moving to a different county, this could impact your claims payment. This information is utilized for the member directories. A P.O. Box will not be accepted as an office address
- Payee Address/Telephone Change
  - Note: Changes requested to a Group's information will only be accepted if submitted by the Group. Supporting documentation must be submitted on group letter head
- Email Address Change
- Ethnicity (Optional)
- Other Change \_\_\_\_\_

Please submit your request with supporting documents via fax (713.338.4807) or email to [providerservices@memorialhermann.org](mailto:providerservices@memorialhermann.org).

Name of submitter\*: \_\_\_\_\_

Title\*: \_\_\_\_\_

Phone\*: \_\_\_\_\_

\* Indicates a required field