Provider Data Update Notification Form

If requesting termination from a provider network, please contact Provider Relations at providerservices@apex4health.com

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@apex4health.com.

Name of submitter*:_____

Title*:_____

Phone*:_____

* Indicates a required field

MEMORIAL HERMANN Health Plan