MEMORIAL HERMANN Health Plan

# REQUEST FOR EXECUTED AGREEMENT AUTHORIZATION FORM

Please complete ALL of the following fields, to formally request for a release of information.

Email completed forms to: MHHPContracting@apex4health.com

Name/Title(s) of this form must match the signature on the executed agreement or individual(s) authorized to sign executed agreement.

**Faxed & Incomplete forms will not be considered.**

By signing this form, I_____authorize Memorial Hermann Health Plan, Inc. to release and send if applicable all appropriate papers within the signed executed agreement to the person(s) or entity below.

Provider Office

Provider Name

Tax Identification

National Provider Identifier (NPI)

Authorized

Business Name

E-mail

Mailing Address (*paper copy only*)

City

State

Zip

Certified Mail

- Yes
- No

**Name of Authorized Representative** (*Please Print*):

_____

**Title:**

_____

**Signature:**

_____

**Date:**

_____