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| **PROVIDER INFORMATION FORM** |
| Date: |  |
| Provider First Name:    |  |
| Provider Last Name:  |  |
| Facility Name:(*If different from Provider name*) |  |
| Facility Address: |  |
| County: |  |
| Phone Number: |  |
| E-Mail Address: |  |
| UMPI or NPI: |  |
| Social Security or EIN: |  |
| MNIT’s Log In: |  |
| MNIT’s Password: |  |

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| **CLIENT INFORMATION FORM** |
| **1st Client Name**: |  |
| Client Birthdate: |  |
| Client PMI: |  |
| Case Manager Name: |  |
| Case Manager E-Mail: |  |
| Case Manager Phone: |  |
| **2nd Client Name**: |  |
| Client Birthdate: |  |
| Client PMI: |  |
| Case Manager Name: |  |
| Case Manager E-Mail: |  |
| Case Manager Phone: |  |
| **3rd Client Name**: |  |
| Client Birthdate: |  |
| Client PMI: |  |
| Case Manager Name: |  |
| Case Manager E-Mail: |  |
| Case Manager Phone: |  |