WORKERS COMPENSATION INITIAL AUTHORIZATION TO TREAT FORM

INITIAL AUTHORIZATION TO TREAT FORM

All additional treatments/services beyond first visit need approval from CCMSI. *Andrea Sumner, Phone: 517-347-2359, E-mail: asumner@ccmsi.com*

Employer: please complete this form and send with employee for work-related injury.

Employee Information

Name:	Date:
Date of birth:	Social Security number:
Location where accident/injury occurred:	
Date of injury:	Injured body part(s):
Brief description of injury/accident:	

Employer Information

Employer: Mid Michigan College	
Phone: Human Resources: 989-386-6621	Fax: Human Resources: 989-317-4631
Address: 1375 S. Clare Ave. Harrison, MI 48625	
Authorized signature: Lori Fassett	Printed name & title: Lori Fassett AVP of Human Resources

The employer accepts responsibility and authorizes initial treatment, including diagnostic testing, for the employee listed above under a self-insured workers' compensation program managed by a third-party administrator. The employee is to be treated for injuries under the provisions of the Michigan Worker's Disability Compensation Act.

Billing Information

Workers' compensation insurance/third-party administrator: Cannon Cochran Management Services Inc. (CCMSI)		
Billing address: 2544 Woodlake Circle, Okemos, MI 48864		
Phone: 517.347.2359	Fax: 217.477.4982	Claim number:

All additional treatments/services beyond initial visit need approval from CCMSI. *The employer, via CCMSI, will pay related and reasonable charges provided that these charges are accompanied by medical records submitted directly to CCMSI. The patient is financially responsible for all other services unless otherwise authorized.*

Medical Clinics

McLaren Central Occupational Clinic: Mt. Pleasant.....(989) 773-2339	**MidMichigan Health Urgent Care:** Freeland.....(989) 695-4999
MidMichigan Health Urgent Care: Alma.....(989) 466-3332	Gladwin.....(989) 246-9430
Clare.....(989) 386-9911	Midland.....(989) 633-1350

Please go to page 2

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District name: **Mid Michigan College**		
Employee name:		
Medical Diagnosis *(to be completed by medical provider)*		
Injured body part(s):		
Medical diagnosis:		
Is condition work related? No Yes	Is employee able to return to work full duty? No Yes	Is employee fully disabled? No Yes
If unable to perform full duties, please specify restrictions:		
If employee is fully disabled, what is the estimated time away from work?		
Physician name (please print):		Phone:
Address:		
Physician's signature:		Date:
Date & time of next office visit:		
Please note - all additional treatments/services beyond initial visit need approval from CCMSI. The patient is financially responsible for all other services unless otherwise authorized.		

*****WHEN COMPLETED BY MEDICAL PROVIDER, PLEASE FAX FORM TO:**

MID MICHIGAN COLLEGE, HUMAN RESOURCES, 989-317-4631***