


WORKERS COMPENSATION INITIAL AUTHORIZATION TO TREAT FORM

INITIAL AUTHORIZATION TO TREAT FORM

All additional treatments/services beyond first visit need approval from CCMSI.

Mande Parsons, Phone: 517-347-2342, E-mail: aparsons@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: <p style="text-align: center;">Mid Michigan College</p>		
Phone: Human Resources: 989-386-6621	Fax: Human Resources: 989-317-4631	
Address: 1375 S. Clare Ave. Harrison, MI 48625		
Authorized signature: 	Printed name & title: LOREI FASSETT AVP of HUMAN RESOURCES	
<i>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.</i>		
Billing Information		
Workers' compensation insurance/third-party administrator: Cannon Cochran Management Services Inc. (CCMSI)		
Billing address: 2364 Woodlake Drive, Ste. 100, Okemos, MI 48864		
Phone: 517.347.2331	Fax: 217.477.5970	Claim number:
<i>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.</i>		
Medical Clinics		
McLaren Central Occupational Clinic: Mt. Pleasant.....(989) 773-2339 MidMichigan Health Urgent Care: Alma.....(989) 466-3332 Clare.....(989) 386-9911	MidMichigan Health Urgent Care: Freeland.....(989) 695-4999 Gladwin.....(989) 246-9430 Midland.....(989) 633-1350	

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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? <input type="checkbox"/> No <input type="checkbox"/> Yes	Is employee able to return to work full duty? <input type="checkbox"/> No <input type="checkbox"/> Yes	Is employee fully disabled? <input type="checkbox"/> No <input type="checkbox"/> 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:		
<i>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.</i>		

*****WHEN COMPLETED BY MEDICAL PROVIDER, PLEASE FAX FORM TO:
MID MICHIGAN COLLEGE, HUMAN RESOURCES, 989-317-4631*****