



ALMA PUBLIC SCHOOLS

1500 PINE AVENUE

ALMA, MI 48801

INITIAL AUTHORIZATION TO TREAT FORM

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

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: Alma Public Schools | |
| Phone: 989-463-3111 | Fax: 989-466-2943 |
| Address: 1500 Pine Avenue, Alma, MI 48801 | |
| Authorized signature: _____ | Printed name & title: _____ |
| <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 Clinic | After-hours care |
| Occupational Health - MidMichigan Urgent Care 321 East Warwick Drive Alma, MI 48801 (989)-466-3340 Mon.-Fri. 7:00 a.m.- 8:00 p.m. Sat. & Sun. 8:00 a.m. – 6:00 p.m. | Emergency Room |

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AUTHORIZATION TO TREAT FORM

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| | | |
|--|---|---|
| District name: Alma Public Schools | | |
| 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, please fax to:

Alma Public Schools
Attn: Vickie Eversole
1500 Pine Ave., Alma, MI 48801
Phone: (989)466-7527
Fax: (989)466-2943