**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: | | | | | |
| Phone: | | Fax: | | | |
| Address: | | | | | |
| Authorized signature: | | | | Printed name & title: | |
| *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:  2364 Woodlake Drive, Ste. 100, Okemos, MI 48864 | | | | | |
| Phone:  517.347.2331 | Fax:  217.477.5970 | | 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 Clinic** | | **After-hours care** | | | |
| *Holland Hospital Urgent Care*  *3235 North Wellness Drive, Suite 140*  *Holland, MI 49424* | | *Holland Hospital Emergency Room*  *602 Michigan Ave*  *Holland, MI 49423* | | | |

Please go to page 2

**Authorization to Treat form**

Page 2

|  |  |  |  |
| --- | --- | --- | --- |
| District name: | | | |
| 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, please fax to:

Hamilton Community Schools

Administration Office

4815 136th Ave

Hamilton, MI 49419

Phone: 269-751-5148

Fax: 269-751-7116