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:	Last 4 Digits of Social Security number: XXX-XX- ___ ___ ___ ___	
Location where accident/injury occurred:		
Date of injury:	Injured body part(s):	
Brief description of injury/accident:		

Employer Information	
Employer: Lakeview School District	
Phone: 269-565-2411	Fax: 269-565-2418
Address: 15 Arbor Street, Battle Creek, MI 49015	
Immediate Supervisor's signature:	Immediate Supervisor's 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.*		

Urgent Care Facility	**Emergency Care Facility**
Bronson Urgent Care – Battle Creek 2151 W. Columbia Ave Battle Creek, MI 49015 (269) 979-6888	Bronson BC Health System 300 North Ave. Battle Creek, MI 49017 (269) 245-8000

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AUTHORIZATION TO TREAT FORM

District name: Lakeview School District		
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:

Lakeview School District
Attn: Tricia Mack - Human Resources
15 Arbor St
Battle Creek, MI 49015
Phone: 269-565-2411
Fax: 269-565-2418