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# **AUTHORIZATION FOR TREATMENT**

## **Workers Compensation**

This form authorizes a health care provider to treat the following Edustaff Employee:

\_\_\_\_\_

for a work-related injury that occurred on \_\_\_\_\_

at \_\_\_\_\_

### **Send all billing information to:**

Accident Fund

PO Box 40790

Lansing, MI 48901

Policy #100100699