Gibraltar School District

19370 Vreeland Road, Woodhaven, MI 48183 | Phone (734) 379-6355 | Fax (734) 379-6359
Visit our website at: www.gibdist.net | Cell: (734)752-7028 | Tax Id: 38-6004145
Shawn M. Stirling, Finance Manager | Email: stirlis@gibdist.net

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**
HENRY FORD OCCUPATIONAL HEALTH *HENRY FORD MEDICAL CENTER-WOODHAVEN* *ALLEN/WEST RD ACROSS FROM MEIJER* *8:00 – 4:30 P.M. M-F* *22505 ALLEN RD* *WOODHAVEN, MI 48183* *P. 734-671-2870 F. 734-671-2860*	*HENRY FORD HEALTH CENTER BROWNSTOWN* *23050 WEST ROAD* *BROWNSTOWN, MI 48183* *P: 734-287-9880*

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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/scan to:

Gibraltar School District
Attn: Pamela Kruso
19370 Vreeland Rd., Woodhaven, MI 48183
Phone: 734-379-6354
Fax: 734-379-6359
Email: krusop@gibdist.net