

# Gibraltar School District

19370 Vreeland Road, Woodhaven, MI 48183  
Visit our website at: [www.gibdist.net](http://www.gibdist.net)  
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## 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:
<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: 2455 Woodlake Circle, Okemos, MI 48864		
Phone: 517.347.2331	Fax: 217.477.5970	Claim number:
<b>All additional treatments/services beyond initial visit need approval from CCMSI.</b> <i>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		
Southgate Urgent Care 14523 Northline Rd Southgate, MI 48195 P-734-324-7800 F-734-324-7801		

# AUTHORIZATION TO TREAT FORM

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District name:		
Employee name:		
<b>Medical Diagnosis (to be completed by medical provider)</b>		
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:		
<b><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></b>		

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