## CHEBOYGAN. OTSEGO . PRESQUE ISLE EDUCATIONAL SERVICE DISTRICT

6065 Learning Lane (231) 238-9394



Indian River, MI 49749 Fax (231) 238-8551

## INITIAL AUTHORIZATION TO TREAT FORM

All additional treatments/services beyond first visit need approval from CCMSI.

NAME OF TAXABLE PARTY.	omplete this form and send with e	mployee for work-related injury.
Employee Infor	mation	
Name:		Date:
Date of birth:		Social Security number:
Location where acc	ident/injury occurred:	
Date of injury:	Injured body part(s):	
Brief description of	injury/accident:	
Employer Infor	rmation	
Employer: Chebovgan-Otsego	-Presque Isle Educational Service	District (COPESD) Contact: Bridget Merchant
Phone: 231-238-9394		Fax: 231-238-8551
Address:		231-230-0371
	e, Indian River, MI 49749	
Authorized signatus		Bridget Merchant, Finance Assistant-HR merchantb@copesd.org
		nitial treatment, including diagnostic testing, for the employee
		tion program managed by a third-party administrator. The sions of the Michigan Workers Disability Compensation Act.
Billing Informa		
Workers' compensa	tion insurance/third-party admini	
	lanagement Services Inc. (CCMSI	()
Billing address: 2364 Woodlake Dri	ive, Ste. 100, Okemos, MI 48864	
Phone:	Fax:	Claim number:
517.347.2331	217.477.5970	
related and reasons	able charges provided that these c	it need approval from CCMSI. The employer, via CCMSI, will pay harges are accompanied by medical records submitted directly to other services unless otherwise authorized.
	s - Call First if Possible	Medical Clinics - Call First if Possible
	up – Indian River Clinic, v., Indian River, MI 49749	Thunder Bay Community Health Service 21258 M-68 Hwy, <b>Onaway</b> , MI 49765
OMH Medical Group - Lewiston 3040 Bourn St., Lewiston, MI 49756		Grayling Community Health Center 1100 E. Michigan Ave., Grayling, MI 49738
OMH Walk-In Clinic – Gaylord 1996 Walden Dr. Gaylord, MI 49735		Rogers City Health Center 205 S. Bradley Hwy. Rogers City, MI 49779
	s Specialty Clinic – Elmira I Elmira, MI 49730	

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## AUTHORIZATION TO TREAT FORM Page 2

Employee name:	
Medical Diagnosis (to be completed by me	edical provider)
njured body part(s):	
Medical diagnosis:	<sub>a</sub> a
s condition work related? Is employee able to return to work full duty?  No Yes Yes	Is employee fully disabled?  □ No □ Yes
f unable to perform full duties, please specify restrictions:	
f employee is fully disabled, what is the estimated time away from work?	
	*
Physician name (please print):	Phone:
Address:	2 %
Physician's signature:	Date:
Date & time of next office visit:	

When completed, please fax to:

Cheboygan-Otsego-Presque Isle Educational Service District (COPESD)
Attn: Bridget Merchant, Human Resources
6065 Learning Lane, Indian River, MI 49749

Phone: 231-238-9394 Fax: 231-238-8551

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