AUTHORIZATION TO INVOICE MSU – EMPLOYEE OUTSIDE OF LANSING AREA

Michigan State University
Workers' Compensation Division
(517) 353-4434 or (800) 353-4434

1. ____
(Name of Medical Facility or Physician)

____
(Address of Medical Facility or Physician)

____
(Phone Number of Facility or Physician)

2. ____________________ **is authorized to receive medical tests and treatment**
(Name of Injured Employee)
with payment of services to be provided by Michigan State University if the services are for a work related injury.

3. ______________ ______________ ____________ __________
(Authorized Signature) (University Title) (Work Number) (Date)

4. Service Requested:

☐ Injury Treatment
Was the Incident Observed by Anyone? ☐Yes ☐No

☐ Second Opinion
Why? ____

☐ Other ____

5. Current Injury ____

6. Current Shift (Hours) ____

7. Injured Employee's Current Job ____

8. Job Involves:

	NO	YES	Amount
Lifting	☐	☐	__________
Sitting	☐	☐	__________
Standing	☐	☐	__________
Walking	☐	☐	__________

This authorization will remain in effect until revoked by MSU in writing.
Distribution – Copy to Medical Provider and Department

Michigan State University is an affirmative action, equal opportunity institution.