



**AUTHORIZATION TO INVOICE MSU  
EMPLOYEE OUTSIDE OF LANSING AREA**

**Bill to:** Michigan State University  
Workers' Compensation Division  
1407 S Harrison # 140  
East Lansing, MI 48823  
(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 \_\_\_\_\_  
Witness Name  
 Other \_\_\_\_\_

5. Current Injury \_\_\_\_\_

6. Current Shift (Hours) \_\_\_\_\_

7. Injured Employee's Current Job \_\_\_\_\_

		NO	YES	Amount
8. Job Involves:	Lifting	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Sitting	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Standing	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Walking	<input type="checkbox"/>	<input type="checkbox"/>	_____

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