

## **AUTHORIZATION FOR TREATMENT Workers Compensation**

This form authorizes a health care provider to treat the following EDUStaff Employee:

\_\_\_\_\_

for a work related injury that occurred on \_\_\_\_\_

at \_\_\_\_\_.

### **Send all billing information to:**

Accident Fund  
PO Box 40790  
Lansing, MI 48901

EDUStaff, LLC Workers Compensation Insurance

Policy Carrier: Accident Fund  
Policy Number: WCV6121051