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