MISSISSIPPI WORKERS' COMPENSATION COMMISSION
PETITION TO CONTROVERT

PLEASE COMPLETE ALL INFORMATION **MWCC #:**

Claimant Name: **Address:** **City:** **State:** **Zip:** **SSN:** **Date of Birth:**	**Insurer Name:** **Address:** **City:** **State:** **Zip:**
Employer Name: **Address:** **City:** **State:** **Zip:**	**Claims Administrator (TPA) Name:** **Address:** **City:** **State:** **Zip:** **Phone:**

Comes now the claimant and controverts this cause and in support thereof alleges the following:

1. On the _____ day of _____, _____, claimant received a compensable injury while in the employ of the captioned employer.
2. Claimant's Occupation: _____ Average Weekly Wage: _____
3. ***County*** and place of accident or illness: _____
   A. Nature of work in which claimant was engaged at the time of injury or illness: _____
   _____
   B. Description of accident or illness and how it happened: _____
   _____
   C. Accurately describe the part or parts of body involved or injured, or type of occupational disease: _____
   _____
   D. Date employer first notified of injury or illness and name and title of person notified: _____
   _____
   E. Name and addresses of witnesses: _____
   _____
4. Names and addresses of attending physicians and hospitals with dates medical treatment rendered: _____
   _____
   _____
   A. Was medical treatment furnished by employer? Yes ___ No ___.
   B. Is medical treatment presently being furnished by employer? Yes ___ No ___.
5. Compensation has ___ has not ___ been paid for _____disability from _____ to _____at the rate of $ _____.
   A. Period of temporary disability: _____
   B. Date of maximum medical improvement: _____
   C. Date able to resume employment: _____
   D. Nature, degree and extent of permanent disability: _____
   E. Loss of wage earning capacity, if applicable: _____
6. Injury did ___ did not ___ result in death. Date of death (if applicable): _____
   Name, address, date of birth and relationship of each claimant who was dependent and for whom claim is made is listed on Exhibit "A", attached hereto, and made a part hereof by reference.
7. Are penalties demanded: Yes ___ No ___. If yes, why? _____
8. Other matters in dispute are as follows: _____
   _____

This the _____ day of _____, _____.

Except as required by Miss. Code Ann. § 71-3-7(1) below, medical records are no longer to be filed with the Petition to Controvert. A party to a controverted claim shall not file medical records with the Commission unless attached to a Prehearing Statement, or unless relevant to a motion or response to motion and attached thereto as an exhibit.

However, for injuries occurring on or after July 1, 2012, pursuant to Miss. Code Ann. § 71-3-7(1)(as amended), in all claims in which no benefits,including disability,death and medical benefits,have been paid,the claimant shall file medical records in support of his claim for benefits when filing a petition to controvert. If the claimant is unable to file the medical records in support of his claim for benefits at the time of filing the petition to controvert because of a limitation of time established by Section 71-3-35 or Section 71-3-53, the claimant shall file medical records in support of his claim within sixty (60) days after filing the petition to controvert.

_____
Signature of Claimant or Representative
Name, address, phone number, & bar number of attorney:

_____
_____
_____
_____
_____