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 _____, _____.

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

_____

_____

_____

_____

_____

MWCC Form B-5,11 (Revised 3-15-2008)

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.