MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION: Mississippi

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

PHONE #

SIC CODE

EMPLOYER FEIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)

MS State Agencies SIWCT
PO Box 24208
Jackson, MS 39225

POLICY PERIOD ____ TO ____

CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CCMSI
PO Box 1378
Ridgeland, MS 39158-1378
Phone: 601-899-0148
Fax: 601-899-0160

CARRIER FEIN

POLICY/SELF-INSURED NUMBER

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE

ADDRESS (INCL ZIP)

SEX
☐ MALE (M)
☐ FEMALE (F)
☐ UNKNOWN (U)

MARITAL STATUS
☐ UNMARRIED/SINGLE/DIVORCED (U)
☐ MARRIED (M)
☐ SEPARATED (S)
☐ UNKNOWN (K)

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE

OF DEPENDENTS

NCCI CLASS CODE

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:

#DAYS WORKED WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT
- NO MEDICAL TREATMENT (0) ☐
- MINOR: BY EMPLOYER (1) ☐
- MINOR CLINIC/HOSP (2) ☐
- EMERGENCY CARE (3) ☐
- HOSPITALIZED > 24 HRS (4) ☐
- FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5) ☐

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

SEE BACK FOR INSTRUCTIONS

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WORKERS' COMPENSATION - FIRST REPORT OF INJURY EMPLOYER'S INSTRUCTIONS

GENERAL INFORMITION

EMPLOYER (NAME & ADDRESS INCL ZIP) – The name and address of the entity employing or statutorily responsible for the employee.

SIC CODE – The code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

EMPLOYER FEIN – Employer's Federal Employer Identification Number.

CARRIER/ADMINISTRATOR CLAIM NUMBER – Carrier's claim or file number.

REPORT PURPOSE CODE – A code used with Electronic Data Interchange to define the specific purpose of the report. (Original, Cancel, Change, Correction)

JURISDICTION – State in which you are filing the claim (Mississippi).

JURISDICTION CLAIM NUMBER – Number assigned to claim by Mississippi Workers' Compensation Commission (to be completed by MWCC).

INSURED REPORT NUMBER – The number, if any, used by the employer to identify the claim.

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) – The name and address of the employels facility where the employee was employed at the time of injury, if different from above.

LOCATION #/ PHONE # – The number, if any, assigned by the employer to identify its location where the injury occurred and the phone number.

CARRIER (NAME, ADDRESS & PHONE NO) – The licensed business entity issuing the contract of insurance and assuming financial responsibility for the claim on behalf of the employer.

POLICY PERIOD – The date that the contract/policy under which the claim occurred began and expired.

CHECK IF APPROPRIATE (SELF-INSURANCE) – An indicator that identifies the employer as one who retains the risks arising from their operations and bears the financial responsibility. A jurisdictionally approved or acknowledged employer, group fund, or association assuming financial risk and responsibility for their employee's worker's compensation claims.

CLAIMS ADMINISTRATOR – The business entity providing claim services on behalf of the carrier, or self-insured. The name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

CARRIER FEIN – Carrier's Federal Employer Identification Number.

POLICY/SELF-INSURED NUMBER – The number assigned by the carrier to the insurance contract/policy for the employer; or any similar number assigned to a self-insured employer.

ADMINISTRATOR FEIN – Federal Employer Identification Number of Administrator.

AGENT NAME & CODE NUMBER – The name of the insurance agent and the agents code number if known. This information should be found in the insurance policy.

EMPLOYEE/WAGE INFORMATION

NAME (LAST, FIRST, MIDDLE) – Employee's legally recognized name.

ADDRESS – The mailing address used by the employee.

PHONE – A telephone number where the employee can be reached.

DATE OF BIRTH – The date the employee was born.

SOCIAL SECURITY NUMBER – A number assigned by the Social Security Administration used to identify the employee.

DATE HIRED – The date the injured worker began his/her employment with the employer under which the claim is being filed. If there have been multiple periods of employment, this would be the beginning date of the current employment period.

STATE OF HIRE – State where employee was hired.

SEX – The code which indicates the sex of the employee.

MARITAL STATUS – The code which indicates the marital status of the employee.

OCCUPATION/JOB TITLE – This is the primary occupation of the employee at the time of the accident or exposure.

EMPLOYMENT STATUS – Indicate the employee's work status. The valid choices are: Full-time, Part-Time, Not Employed, On Strike, Disabled, Retired, Unknown, Apprenticeship Full-Time, Apprenticeship Part-Time, Volunteer, Seasonal, or Piece Worker.

NCCI CLASS CODE – A code which corresponds to the primary occupation which the employee was engaged at the time of accident/injury, or injurious exposure. Codes are found in the NCCI BASIC MANUAL FOR WORKERS' COMPENSATION AND EMPLOYERS LIABILITY INSURANCE.

RATE – The reported employee's wage rate at the time of injury.

 # DAYS WORKED/ WEEK – The number of days worked by the employee in a week.

FULL PAY FOR DAY OF INJURY – State whether employee was paid his full wages on the injury date.

DID SALARY CONTINUE – State whether employee's salary was continued by the employer in lieu of compensation benefits.

OCCURRENCE/TREATMENT INFORMATION

TIME EMPLOYEE BEGAN WORK – The time employee began work on date of injury.

DATE OF INJURY/ILLNESS — The date employee was injured.

TIME OF OCCURRENCE – The time employee was injured.

LAST WORK DATE — The date employee last worked following the injury.

DATE EMPLOYER NOTIFIED – The date on which the employer was notified of the injury.

DATE DISABILITY BEGAN – The date on which employee began losing time.

CONTACT NAME/PHONE NUMBER – Name and phone number of employer representative to be contacted for further information.

TYPE OF INJURY/ILLNESS – Briefly describe the nature of the injury or illness, (e.g., Lacerations to the forearm).

PART OF BODY AFFECTED – Indicate the part of body affected by the injury/illness, (e.g., Right Forearm, lower back).

DID INJURYIILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES – Mark yes or no as applicable.

TYPE OF INJURY/ILLNESS CODE – The NCCI code which corresponds to the nature of the injury or illness. (NCCI Table 8: Nature of Injury Codes)

PART OF BODY AFFECTED CODE – The NCCI code which corresponds to the part of the body injured. (NCCI Table 7: Part of Body Codes)

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED – Be specific (e.g., Maintenance Department or Client's office at 452 Monroe Street, Washington, D.C. 26210). If the accident or illness exposure did not occur on the employer's premises, enter address or location.

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED – List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint. Enter "NA" for not applicable if no equipment, materials, or chemicals were being used.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED – Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED – Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (e.g., walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL – Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding, to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

CAUSE OF INJURY CODE – The NCCI code which identifies the cause of injury. (NCCI Table 9: Cause of Injury Codes)

DATE RETURN(ED) TO WORK – Enter the date following the most recent disability period on which the employee returned to work.

IF FATAL, GIVE DATE OF DEATH – Date of death of employee.
WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDEDMIERE THEY USED - Check applicable "yes" or "no" box.

PHYSICIAN/HEALTH CARE PROVIDER (NAME AND ADDRESS) – The name and address of the physician or health care professional providing initial treatment.

HOSPITAL (NAME AND ADDRESS) – The name and address of the hospital where employee was treated (if applicable).

INITIAL TREATMENT – Check applicable choices.

WITNESSES (NAME & PHONE #) – The name(s) and phone number(s) of any one who witnessed the accident.

DATE ADMINISTRATOR NOTIFIED – The date the carrier or claims administrator processing the claim received notice of the injury.

DATE PREPARED – The date this report was prepared.

PREPARER'S NAME & TITLE – The name and title of the person who prepared this report.

PHONE NUMBER – The phone number of the person who prepared this report.

NOTICE

TO

MISSISSIPPI WORKERS' COMPENSATION COMMISSION

OF PHYSICIAN CHOICE

Claimant's Name ____

Employer's Name ____

Injury Date ____

Claim Number ____

I understand that under the Mississippi Workers' Compensation Law I have the right to choose one physician to render treatment to me. I can either accept the physician to whom I am sent to by my employer or choose someone else on my own.

I also understand that any referral to any other doctor must be made by my one chosen physician.

I also understand that my employer (or workers' compensation carrier) must approve any physician change, and if I change doctors without their authorization, I will be responsible for the medical expense for the unauthorized treatment.

With that understanding I state as follows:

☐ I accept as my choice of physician my employer's tender of treatment by

Dr. ____.

☐ I elect to choose my own physician to render treatment, and that choice is

Dr. ____.

____

Claimant's Signature

____

Date

Witnessed by:

____

____

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

(IN COMPLIANCE WITH THE HIPAA PRIVACY RULE)

To: Any licensed physician, chiropractor, medical practitioner, hospital, clinic, pharmacy, home health agency or other medical or medically related facility; employer, consumer reporting agency; insurance company; or the Medical Information Bureau.

For informational purposes pertaining to an insurance claim, I authorize and request the Custodian of Records at the above named entity to disclose to the agents or designees of **Cannon Cochran Management Services, Inc. (CCMSI)**, any and all records containing ***Protected Health Information (PHI)*** created before or after the date of signature below regarding:

Patient Name: ____
Date of Birth: ____
Social Security Number: XXX-XX- _______________________________
Claim Number: ____

This authorization should also be construed to permit agents or designees of **Cannon Cochran Management Services, Inc. (CCMSI),** to copy, inspect and review any and all such records. Records containing **PHI** may include, but are not limited to:

> All medical records, physician's records, surgeon's records, x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films, pathology materials, slides, tissues, physicals and histories, laboratory reports, operating room records, discharge summaries, progress notes, patient in take forms, consultations, prescriptions, nurses' notes, birth certificate and other vital statistic records, communicable disease testing and treatment records, correspondence, psychiatric records, psychological records, psycho-therapy notes, prescription records, medication records, orders for medications, therapists' notes, social worker's records, insurance records, consent for treatment, statements of account, itemized bills, invoices and any other papers relating to any examination, diagnosis, treatment, periods of hospitalization, or stays of confinement.

Unless revoked in writing, this authorization shall remain valid for the length of my claim. In addition, a copy of this authorization may be used in place of and with the same force and effect as the original.

NOTICE

- The individual signing this authorization may request the entity provide them with both a copy of the authorization and a copy of the protected health information ***PHI*** to be disclosed.
- The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing, except to the extent that the entity has already relied upon this Authorization to disclose protected health information ***PHI.***
- This authorization only applies to protected health information ***PHI*** already disclosed by the above named entities. This information could be re-disclosed by the receiving parties; in such case, the disclosed ***PHI*** will no longer be protected by the ***HIPAA Privacy Rule***.

I have read this Authorization and understand that it will permit the entity identified above to disclose ***Protected Health Information (PHI)*** to **Cannon Cochran Management Services (CCMSI).**

____
Signature

____
Date

RETURN-TO-WORK STATUS REPORT

EMPLOYER COMPLETES:

Date of Treatment: ___________________________

Employee Name: ___________________________ Social Security #: _____________________ DOB: ___________________

Date of Accident: ___________________ Accident Description: ___________________________

The following information will be used to help identify appropriate, temporary modified or light duty work for our employees whenever possible. Your partnership in caring for our employees is sincerely appreciated.

We Hereby Authorize Today's Treatment for the above named employee.

- ❑ Urinalysis/Drug Screen Required Type_____________________
- ❑ Blood/Alcohol/Panel IV Drug Test Required

Employer	Employer Representative	Date	Phone Number
____________	____________	____________	____________

EMPLOYEE COMPLETES:

I have been informed that a drug/alcohol test will be administered. I agree to these tests and I give my permission to release the results to my employer, ____

Employee Signature:___________________________ Date:___________________

PHYSICIAN COMPLETES:

Diagnosis: ___________________________ Right or Left_____ Bilateral______

Treatment Plan: ___________________________

Medication Provided: ☐ NO ☐ YES List: ___________________________

Prescription Provided: ☐ NO ☐ YES List: ___________________________

RETURN TO WORK STATUS

_____ Employee has **NO RESTRICTIONS** and may return to work Full-Duty as of____________________ (Date).

_____ Employee is **UNABLE TO WORK**. Estimated date of return to modified duty____________________ (Date).

_____ Employee may return to work on ______________ (Date) with the following **RESTRICTIONS** as indicated below.

Duration of restrictions: ____________________ (Date) to ____________________ (Date).

THE EMPLOYEE IS ABLE TO: (CHECK ALL THAT APPLY)

	NEVER	UP TO 2 HOURS	3 - 4 HOURS	5 - 6 HOURS	7 - 8 HOURS	NO RESTRICTIONS
Lift or Carry						
5-10 pounds						
10-20 pounds						
20-30 pounds						
30-50 pounds						
50-100 pounds						
Sitting						
Driving						
Standing						
Walking						
Climbing						
Bending						
Kneeling						
Pushing/Pulling						
Reaching above Shoulder Height						
Repetitive use of hands- Circle left or right						

Estimated full-duty return to work date:____________________

COMMENTS/OTHER:

Date of exam: ____________________ Date of next visit: ____________________

Medical Provider's Signature:___________________________ Date:____________________

FAX COMPLETED COPY TO CCMSI 601-899-0160

WAGE AND EMPLOYMENT INFORMATION

Employee:____

Date of Alleged Injury:_____________________________________

Date Hired:____

Last Day Worked:_______________________________________

Pay Rate: Per Hour __________ Per Day __________ Per Week __________ Per Month __________

Weeks	Week Ending	No. Days	Gross Wages	Weeks	Week Ending	No. Days	Gross Wages
1.				27.			
2.				28.			
3.				29.			
4.				30.			
5.				31.			
6.				32.			
7.				33.			
8.				34.			
9.				35.			
10.				36.			
11.				37.			
12.				38.			
13.				39.			
14.				40.			
15.				41.			
16.				42.			
17.				43.			
18.				44.			
19.				45.			
20.				46.			
21.				47.			
22.				48.			
23.				49.			
24.				50.			
25.				51.			
26.				52.			

I hereby certify that the above is a true and correct account, as taken from our timebooks or payroll records, of the wages paid to the above named employee for the periods indicated.

Date______________________ ____

Employer

By:____

Position:_____________________________________

Telephone Number:____________________________

Return to:

CCMSI
P. O. Box 1378
Ridgeland, MS 39158
Fax: 601-899-0160

Workers Compensation Preferred Providers List

PHYSICIAN	SPECIALTY	BODY PART	CLINIC NAME	STREET ADDRESS	TOWN	ZIP	PHONE
Robinson, Joseph	Dermatologist			501 Marshall St.	Jackson	39202	944-0116
Loria, Jr, Philip R.	Dermatologist			2204 Jefferson Davis Dr	Oxford	38655	662-236-6850
McCowan, Nancye	Dermatologist		UMC	2500 North State St.	Jacckson	39216	601-815-3374
Biloxi Regional Wellness	GP				Biloxi		888-977-3319
Chance, Rickey	GP			967 Cedar Lake Rd., Suite B	Biloxi	39532	228-396-0037
Med Analysis	GP				Biloxi		228-388-2599
TrustCare	GP		TrustCare	601 Hwy 80	Clinton	39056	601-708-1480
Baptist Clinic	GP				Clinton		
Hull, Joseph	GP		Primary Care	15444 DeDeaux Rd., Suite B	Gulfport	39503	228-832-9038
TrustCare	GP		TrustCare	1645 W. Government St	Brandon	39042	601-829-6600
TrustCare	GP		TrustCare	4880 I-55 Frontage Rd	Jackson	39211	601-487-9199
TrustCare	GP		TrustCare	1706 W. 10th Street	Laurel	39440	601-682-0455
TrustCare	GP		TrustCare	786 Lake Harbour Rd	Ridgeland	39157	601-499-0022
TrustCare	GP		TrustCare	1067 Highland Colony Pkwy	Ridgeland	39157	601-707-3978
Morris, Tim	GP				Jackson		
Pruitt, Charles	GP				Magee		
Koehler, Kevin	GP		Pontotoc Family Clinic	345 Hwy. 15 N.	Pontotoc	38863	662-489-7430
White, John	GP		Hubbard Clinic	P. O. Box 429	Verona	38879	662-566-5593
TrustCare	GP		TrustCare	1710 Old Fannin Road	Flowood	39232	601-487-9191
TrustCare	GP		TrustCare	6176 US Hwy 80	Hattiesburg	39402	601-475-0444
Davis, John	Neuro		NewSouth NeuroSpine	2470 Flowood Dr Suite 2100	Flowood		
Neill, John	Neuro		New South NeuroSpine	2470 Flowood Dr Suite 2100	Flowood	39232	(601) 936-0400
Brophy, John	Neuro	Back			Memphis		
Windham, Thomas	Neuro			2204 Jefferson Davis Dr.	Oxford	38655	662-236-6850
Smith, Terry	Ortho	Back		180-B Debuys Rd	Biloxi	39531	228-388-1823
Wegener, Eric	Ortho	Hand	Plastic & Hand Surgery Associates	2550 Flowood Dr.	Flowood	39232	601-939-9999
Barbieri, Rocco	Ortho	Hand	Southern Bone & Joint		Hattiesburg		601-554-7400

Charoglu, Constantine	Ortho	Hand	Southern Bone & Joint		Hattiesburg		601-554-7400
Barrett, Gene	Ortho	Knee	UMC	2500 N State St	Jackson		601-354-4488
Dulske, Michael	Ortho	knee			Jackson		601-987-8200
Ethridge, Chris	Ortho	hand			Jackson		601-936-4263
Geissler, William	Ortho	Knee/upper ext.			Jackson		601-984-6525
Noblin, Dr.	Ortho		Bienville Ortho		Ocean Springs		
Palumbo, Dr.	Ortho		Bienville Ortho		Ocean Springs		
Salloum, Dr.	Ortho		Bienville Ortho		Ocean Springs		
Terry, Cooper	Ortho	Back/shoulder		497 Azalea Drive Suite 102	Oxford	38655	662-234-0424
Varner, James	Ortho	shoulder		7900 Airways Blvd.	Southaven	38671	662- 536-2526
Phillips, Clyde	Ortho	shoulder	Tupelo Bone & Joint	1464 Medical Parks Circle	Tupelo	38801	662-844-8699
Pillow, William	Ortho	knee/shoulder	N MS Orthopedics	808 Garfield Street	Tupelo	38801	662-377-6700
Rice, William L.	Ortho	shoulder	N MS Med Clinic	4381 S Eason Blvd Ste 303	Tupelo	38801	662-840-5747
Murrell, Samuel	Ortho w/spine fellowship	Back	Orthomemphis	1203 Ridgeway, Ste 203	Memphis, TN	38119	901-763-3222
Dix, Brian	Pain Mgt			15190 Community Rd.	Gulfport	39503	228-831-0050
Overmyer, Kent	Pain Mgt			3017 13th St	Gulfport	39501	228-831-0050
Auzenne, Greg	Pain Mgt		The Pain Treatment Center Rush Health Systems	1314 19th Ave.	Meridian	39301	601-703-4910 or 601-703-4362
Dodd, Edwin	Pain Mgt		Jackson Pain Center	1190 N State St Suite 102	Jackson	39202	601-751-3611
Chen, Joe	Pain Mgt.		Suncoast Pain Management	4 Doctors Drive	Ocean Springs	39564	228-818-0053
Summers, Jeff	Pain Mgt/Anesthesiologist				Jackson		
Katz, Howard	Physiatrist	all -head			Jackson		601-968-0894
Vohra, Rahul	Physiatrist		NewSouth NeuroSpine	2470 Flowood Dr.	Jackson	39232	601-664-1213
Maggio, Henry	Psychiatrist			4501 15th Street	Gulfport	39501	228-864-4769
Webb, Mark	Psychiatrist				Jackson		

Koestler, Angela	Psychologist				Jackson		
Manning, Edward	Psychologist			2500 N. State St.	Jackson	39216	601-984-5521
Aldred, Lewis	Pulmonologist	Lung	Hattiesburg Clinic/Pulmonary Medicine	415 S. 28th Ave.	Hattiesburg	39401	601-268-5650
Happel, Kyle	Pulmonologist	Pulmonary/Critical Care & Allergy/Immunology	LSU Healthcare Network Clinic	3700 St. Charles Ave, 4th Floor	New Orleans	70115	504-412-1517
French, Shawn	Pulmonologist	Lung		2113 Government St., Suite K-7	Ocean Springs	39564	228-254-1366
Russell, Bill	Radiologist		Baptist				601-940-9679 (Cell)
Hales, Shan	Toxicology		MS Crime Lab, section chief				
Rigdon, Edward	Vascular Surgeon	Vascular		P. O. Box 6019	Brandon	39047	601-825-1975
Raju, Ashish	Vascular Surgeon	Vascular	The Rane Center	971 Lakeland Drive	Jackson	39216	601-939-4230