DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-13024A (07/08)

MEDICAID PURCHASE PLAN PREMIUM EMPLOYER WAGE WITHHOLDING INFORMATION AND INSTRUCTIONS

The Wisconsin Medicaid Purchase Plan requires information to enable the Medicaid Purchase Plan to authorize and pay for medical services provided to eligible members.

Members are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information shall include but is not limited to information concerning eligibility status, accurate name, address, and Medicaid identification number (DHS 104.02 [4], Wis. Admin. Code).

Under s. 49.45 (4), Wis. Stats., personally identifiable information about Medicaid applicants and members is confidential and is used for purposes directly related to the Medicaid program administration such as payment of premiums by members. Failure to supply the information requested by the form may result in denial of Medicaid payment for services.

INSTRUCTIONS:

Medicaid Purchase Plan Members

Your employer should fill out this form if you want your Medicaid Purchase Plan (MAPP) premium payment to be taken out of your paycheck. If you choose this option, fill in your MAPP Case Number found on your MAPP premium notice. Give the Employer Wage Withholding Form, along with the Electronic Funds Transfer (EFT) form, to your employer. You may also have your employer call 1-888-907-4455 to request that the forms be mailed to the employer.

Employer Instructions for Completing This Form

Fill out the employee's last and first name, Social Security Number, and monthly MAPP premium amount.

You may pay the employee's MAPP premiums either by EFT or by direct payment.

- **Electronic Funds Transfer**
  If you (the employer) choose to pay by EFT, complete the Member / Employer Electronic Funds Transfer form. Send the form to the address listed at the bottom of the EFT form. MAPP will then take the entire premium amount out of your checking account once per month.

  If you choose to fax the form, you may fax it to 1-608-221-8185.

- **Direct Payment**
  If you choose to make a direct payment each month, you will receive a premium notice each month. Send your payment with the premium notice and completed Employer Wage Withholding form to:

  Medicaid Purchase Plan
  P.O. Box 6738
  Madison, WI 53716-0738.

- **Employer Information**
  Fill out employer's name and address.

If you have any questions regarding the above information, please call 1-888-907-4455.

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-13024 (07/08)

STATE OF WISCONSIN

MEDICAID PURCHASE PLAN PREMIUM EMPLOYER WAGE WITHHOLDING

INSTRUCTIONS: Type or print clearly. Before completing this form, read Information and Instructions on the reverse side of this form. Complete this form for your employee (and Electronic Funds Transfer (EFT) form, if applicable). If you have any questions, call 1-888-907-4455.

Employee Information

Name — Employee's (Last, First, Middle Initial)	Medicaid ID Number of Case Head Enrolled in MAPP
Social Security Number — Employee's	Monthly Premium Amount

Electronic Funds Transfer
If you want to pay the premium via monthly EFT, complete the Member / Employer EFT form. You can fax it to 1-608-221-8185.

Direct Payment
If you want to pay the premium via direct payment, send your payment, payable to Medicaid Purchase Plan (MAPP), and this completed form to the address listed below. Do not send cash.

Employer Information

Name — Employer's	Telephone Number	
Address — Employer's		
City	State	ZIP Code
SIGNATURE — Employer		Date Signed

DISTRIBUTION: Mail completed form along with direct payment to:

RESET FORM

Medicaid Purchase Plan
P.O. Box 6738
Madison, WI 53716-0738
Telephone: 1-888-907-4455
Fax: 1-608-221-8185