BHSF Employer-MPP
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IV

MEDICAID PROGRAM
Wage Verification Request

TO: _____ FROM: Louisiana Medicaid Program_____

_____ _____

_____ _____

_____ _____

DATE: _____

_____ _____ _____

Name of Applicant/Eligible SSN Case ID No.

My signature below gives you permission to provide information about my current, past, or expected employment and insurance coverage to Louisiana's Medicaid Program.

_____ _____

Signature of Applicant/Eligible Date

❑ The person named above applied for or is receiving health coverage through the Medicaid Purchase Plan.

❑ It is necessary to verify his/her current or anticipated income and health insurance coverage. A form is provided on the back of this letter for your convenience in giving us this information. If this person has not actually started to work, please estimate as accurately as possible what his/her wages will be and whether he/she will have insurance coverage.

❑ The Medicaid Program is reviewing the past eligibility for Medicaid of the person named above. We must have exact information for our investigation.

❑ We understand that the person named above was employed by your business from _____ to _____. It is necessary that we have exact gross income amounts earned during each pay period. A form is provided on the back of this letter for your convenience in giving us this information. Please check the Social Security number we have provided carefully against your records.

❑ We have contacted your employer, _____, about your employment there from _____ to _____. The information we asked for has not been provided. We need your help to find out about the actual _____ that you received. Please contact your employer and have him fill out the back of this letter. We **cannot** make a decision about your Medicaid health coverage without this information.

Please return the information requested above to us by _____. With this letter is a stamped, self-addressed envelope for you to use.

Thank you for your cooperation. Your help is appreciated.

Sincerely,

_____
Agency Representative

_____
Telephone Number

1. Name of Employee | Social Security Number

Address of Employee

Name of Employer

Date Started | Date Expected to Start

2. If terminated, give: Last Day Worked _____ Amount of Last Check $_____

3. Check how often the employee is (was or will be) paid and complete the chart below. Please give us gross pay before any deductions.

❑ Weekly (show 4 most recent) ❑ Twice Monthly (show 2 most recent)

❑ Every Two Weeks (show 2 most recent) ❑ Monthly (show 1 most recent)

Date Wages Received OR Anticipated	**Period Ending** (not applicable to anticipated wages)	**Number of Hours Worked OR Anticipated**	**Gross Pay OR Anticipated Pay**	**Federal Tax Withheld**	**State Tax Withheld**	**Medicare Tax Withheld**	**Social Security Paid**
			$	**$**	**$**	**$**	**$**
			$	**$**	**$**	**$**	**$**
			$	**$**	**$**	**$**	**$**
			$	**$**	**$**	**$**	**$**

4. If taxes are <u>not</u> withheld, please explain why. _____

_____

5. If this person is a contractor, will IRS Form 1099 be issued? ❑ Yes ❑ No

6. Is/was employee covered by health insurance? ❑ Yes ❑ No If yes, please provide:

Name of Insurance Company _____

Claims Filing Address _____

Policy # _____ Date of Entitlement _____

Type of Coverage (group, hospital, major medical) _____

Who is/was covered? _____

What is the monthly premium amount? _____

_____ _____ (_____)_____

Signature of Employer | Date | Telephone Number