



P.O. Box 8738, Dayton, OH 45401-8738 | CareSource.com

Employer Payroll Deduction Authorization

The person submitting this form wishes to have deductions made from their payroll distribution and sent to CareSource for Healthy Indiana Plan (HIP) POWER account contribution (PAC) payments. The employee should complete the "Employee Information" below, and a copy of the completed form should be faxed or mailed to CareSource at the address on the bottom of this form. Payroll deductions associated with this employee's request should also be mailed to the address below. Please call CareSource Member Services at 1-844-607-2829 (TTY: 1-800-743-3333 or 711) with questions.

HIP Member (Employee) Information:

Name: _____

RID#: _____

Address: _____

Name of Employer: _____

Deduction Begin Date: _____

Amount to Be Withheld Each Pay Period: \$ _____

Please list how you are paid:

Weekly Every two weeks Monthly Other (please list): _____

Authorization

I hereby authorize _____ to make deductions from any compensation or monies due to me in the amount listed above. The monies deducted will be applied to contributions required to be made to CareSource, for participation in HIP. The deductions will be taken through the current calendar year, or until I no longer wish to participate or I terminate my employment.

Employee Signature: _____ Date: _____

By signing this form, I attest that I have read and understand the above authorization.

Employer Information:

Payroll Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Contact Phone: _____

Employer agrees to this optional program to allow employee payroll deductions and forwarding to CareSource?

Yes No

Please mail this form to:
CareSource Billing Department
P.O. Box 8738
Dayton, OH 45401-8738