Employer Payroll Deduction Authorization Form

If you wish to have your CareSource, Healthy Indiana Plan (HIP) POWER account contribution (PAC) deducted from your paycheck, please fill out the "Employee Information" below**. Then mail a copy of the completed form to CareSource at the address on the bottom of this form. Please call CareSource Member Services at 1-844-607-2829 (TTY: 1-800-743- 3333 or 711) with questions. We are open from 8 a.m. to 8 p.m., Monday-Friday.**

Please note: If you are not employed at this time or do not have a POWER account contribution, you do not need to fill out or send this form.

HIP Member (Employee) Information:

Member Name: _____

RID#: _____

HIP Member Employer Information:

Name of Employer: _____

Payroll Address: _____

City:_____ **State:**_____ **Zip:** _____

Payroll Contact Name:_____ **Payroll Contact Phone:** _____

Deduction Start Date: _____

Amount to be Withheld Each Pay Period: $_____

Please list how you are paid:

☐ **Weekly** ☐ **Each two weeks** ☐ **Monthly** ☐ **Other (please list):** _____

Authorization

I allow _____ to make deductions from any pay or monies due to me in the
(Name of Employer)
amount listed above. The monies deducted will be used for payments needed to take part in HIP through CareSource. The deductions will be accepted by CareSource as long as the employer pays. If the employer does not pay, I will be in charge of paying CareSource.

Member Signature:_____Date:_____
By signing this form, I attest that I have read and understand the above agreement.

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