

# MEDICAID PROGRAM

## Wage Verification Request

TO: _____ _____ _____ _____	FROM: Louisiana Medicaid Program _____ _____ _____
DATE: _____	

_____ Name of Applicant/Eligible	_____ SSN	_____ Case ID No.
<b>My signature below gives you permission to provide information about my current, past, or expected employment and insurance coverage to Louisiana's Medicaid Program.</b>		
_____ 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 <small>(not applicable to anticipated wages)</small>	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 not 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