MDwise
A McLaren Company

Billing & Payment Center
PO Box 1768
La Porte, IN 46350
Phone: 866-539-4092
Fax: 219-362-4422

MDwise Healthy Indiana Plan (HIP) Employer and Other Third Party Contribution Form

This form is used to coordinate the payment of Healthy Indiana Plan Member POWER Account Contributions. Please complete the information below so that we may apply the payment and post it correctly. All fields must be completed for proper payment application.

What type of entity are you? ☐Employer ☐Non-profit (501c-3) ☐Other Third Party

Please complete the following information in full, except where listed as optional:

Legal Entity Name	Billing Address (Include City, State, and ZIP)
Employer Identification Number (EIN) or Tax ID	
Primary Contact Name	Primary Contact Phone Number
Primary Contact Email (optional)	Primary Contact Fax Number (optional)

Preferred Contribution Frequency:
☑One-time Contribution
☐Monthly Contribution
☐Benefit Period (Annual) Contribution

Select your payment type from the available options:
☑Business/Cashier's Check or Money Order
☐Credit Card
☐ACH/E-check

By signing this document, I _____, assert that I am authorized to issue
Printed Name
monies on behalf of the above-listed company or organization, which certifies that the member(s) information (listed on the following page) was obtained with permission, that the member(s) consent(s) to the PAC contribution in the member(s)' behalf, and that a signed HIPAA consent form or proof of employment covering the date of contribution can be produced upon request for a period of at least seven years after the payment is made.

Signature: _____ Date: _____

Title:

_____

Important Note: If you are making a one-time payment or if another third party has already contributed to the member's POWER account contribution, any amount in excess of the member's remaining annual contribution amount will be refunded back to you at the end of the member's benefit period.

Member's Name	RID Number	% of monthly contribution OR $ of one-time payment