WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01567 (12/2018)
Wis. Stat. § 49.89(3)

LEGAL

LONG-TERM CARE INSURANCE POLICY – ASSIGNMENT OF BENEFITS

Use of Form: Completing this form is voluntary, but failure to complete this form and send it to your long-term care insurance carrier and a copy to the Third-Party Liability (TPL) Unit at the Department of Health Services (DHS) may result in denial of your application for Medicaid or an end to your current Medicaid. Providing your Social Security number is voluntary and will only be used for the direct administration of the Medicaid program. According to Wis. Stat. § 49.89(3), an individual applying for Medicaid must assign insurance benefits to the state's Medicaid agency. This form serves as a request to your long-term care insurance carrier to assign current or future insurance payments to the State of Wisconsin.

Applicant/Member Instructions: Send this completed form to your long-term care insurance carrier and mail a copy to:
State of Wisconsin DHS
TPL Unit
PO Box 6220
Madison, WI 53784

Note: If you receive long-term care insurance payments, you must write on the back of the insurance check "Pay to the order of the State of Wisconsin" and sign the back of the check. Mail the check and corresponding Explanation of Benefits (EOB) to: State of Wisconsin DHS, TPL Unit, PO Box 6220, Madison, WI 53784 until benefits are assigned to the State of Wisconsin.

Name – Long-Term Care Policy Insured (Last, First MI)		Social Security Number	
Name – Long-Term Care Policy Holder (Last, First MI)		Policy Number	
Address	City	State	Zip Code
Name – Long-Term Care Insurance Carrier		Phone Number	
Address	City	State	Zip Code

I hereby assign the above-named benefits to the State of Wisconsin.

I, _____, have applied for state Medicaid and request that all current or future payments for the long-term care insurance policy identified above be made payable to the State of Wisconsin. Those payments must be sent to:

STATE OF WISCONSIN DHS
TPL UNIT
PO BOX 6220
MADISON WI 53784

SIGNATURE – Long-Term Care Insurance Policy Owner	Date Signed
SIGNATURE – Power of Attorney Agent for the Policy Owner (if applicable)	Date Signed

RESET FORM