

MILWAUKEE
MILWAUKEE ENROLLMENT SERVICES
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State of Wisconsin

PIN #: 0000000000

Mailing Date: 09/16/2025

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Milwaukee Enrollment Services

Phone: 888-947-6583

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Online at access.wi.gov



The State of Wisconsin is an equal opportunity service provider. This letter contains information that affects your benefits. If you need this material in a different format because of a disability or if you need this letter translated or explained in your own language, please call 1-888-947-6583. These services are free.

How to Set Up Employer Wage Withholding

You (and/or someone in your household) applied for health care benefits through a program called the Medicaid Purchase Plan (MAPP). To get MAPP benefits, you must pay a monthly fee called a premium.

One of the ways you can make your premium payments is by signing up for employer wage withholding. Employer wage withholding is when your employer keeps money from your paycheck to pay your MAPP premium.

To sign up for employer wage withholding, have your employer complete the attached wage withholding and electronic funds transfer forms and mail them to:

Medicaid Purchase Plan
PO Box 6738
Madison, WI 53716-0738

Other ways to pay

If employer wage withholding isn't the right option for you, there are other ways you can pay your MAPP premium.

- On the ACCESS website at access.wi.gov or through the MyACCESS mobile app, you can:
 - Make an online premium payment each month, or
 - Set up ACCESS AutoPay for automatic payments from your credit card, debit card, or checking or savings account.

- You can also set up electronic funds transfer (EFT) from a bank account by filling out the enclosed Member/Employer EFT for MAPP Premiums, F-13023, form.
- You can mail your premium statement and a check or money order every month to:
Medicaid Purchase Plan
P.O. Box 93187
Milwaukee, WI 53293-0187

Questions?

If you have questions about setting up employer wage withholding or electronic funds transfer, call 888-907-4455.

SAMPLE

Member/Employer Electronic Funds Transfer for Medicaid Purchase Plan Premiums

Instructions

The Member/Employer Electronic Funds Transfer may be used by members who are making their own payments, as well as employers who are withholding payments on behalf of employees who have Medicaid Purchase Plan (MAPP) health care coverage.

Fill out this form to automatically deduct funds from a checking or savings account on the third of each month for the premium payment. If the third falls on a weekend or holiday, funds will be taken from the account the following business day. Employers must complete a separate form for each employee. To have funds taken out automatically, fill in your name, your MAPP Case Number found on your MAPP premium notice, and your checking or savings account details.

- **Receiving Bank/Savings and Loan/Credit Union**

Enter the name of the bank, savings and loan, or credit union in the space. If it is a branch office, enter that information under "Branch." Include the city, state, and ZIP code where the bank, savings and loan, or credit union is located. Use the information for the branch visited most frequently.

- **Account Type**

Check the box for the type of account, checking or savings, from which the funds should be taken.

- **Bank Transit Routing Number and Bank Account Number**

These numbers can be found on the bottom of your checks and deposit slips. **A voided check or deposit slip must be attached to the electronic funds transfer (EFT) form.** The bank transit routing number is the first nine digits. The following number, up to 17 digits in length, is the bank account number. Contact the bank, savings and loan, or credit union to clarify these numbers.

- **Names(s) and Signature(s) – Account Owner and Co-owner**

Print the names of the account's owner and co-owner if it is a joint account. The account owner, and co-owner if applicable, must sign and date the form.

- **Signature — Employer**

If the member decides to pay the premium payment using employer wage withholding, and the employer chooses to pay using EFT, the employer will need to fill out and sign this EFT form.

Under s .49.45(4), Wis. Stats., personally identifiable information about applicants and members is confidential and is used for purposes directly related to program administration such as payment of premiums by members. Failure to supply the information requested by the form may result in denial of payment for services.

If there are any questions regarding the above information, call 888-907-4455.

Member/Employer Electronic Funds Transfer for Medicaid Purchase Plan Premiums

Instructions: Type or print requested information clearly. **A voided check or deposit slip must be attached to this form for verification of correct information.**

Name(s) on Account		MAPP Case Number
I give permission to begin taking money out of my (our) checking/savings account named below, at the bank/savings and loan/credit union named below.		
Receiving Bank / Savings and Loan / Credit Union		Branch
Address		
City	State	ZIP Code
Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings		
Bank Transit Routing Number (Nine-digit number)		
Bank Account Number (Maximum 17 digits)		
This permission will remain in effect until the Department of Health Services (DHS) has received written notice from me (either of us) to end it, in order to allow DHS and US Bank a reasonable opportunity to act on it. If I lose MAPP, I understand my electronic funds transfer will end.		
Name — Primary account owner		
Signature — Primary account owner		Date Signed
Signature — Account co-owner (if applicable)		Date Signed
Signature — Employer (Required when premium is taken out of member's paycheck)		Date Signed

All written debt authorizations must provide that the receiver may revoke the authorization only by notifying the originator in the manner specified in the authorization.

Mail completed form to:
MAPP/ Premium Unit
PO Box 6738
Madison, WI 53716-0738
Fax: 608-221-8185

Once your completed form has been received and processed (approx. 3 weeks), you will get a letter confirming whether your EFT account is active. You must pay your MAPP premium another way until the month listed on your EFT confirmation letter.

Medicaid Purchase Plan Premium Employer Wage Withholding

Instructions:

Your employer should fill out this form if you want your Medicaid Purchase Plan (MAPP) premium payment taken out of your paycheck. Fill in your MAPP Case Number found on your MAPP premium notice.

Employer Instructions:

Fill out the employee's last and first name, Social Security number, and monthly MAPP premium amount.

You may pay the employee's MAPP premiums either by Electronic Funds Transfer (EFT) or by direct payment.

- **Electronic Funds Transfer**

If you (the employer) choose to pay by EFT, complete Member/Employer Electronic Funds Transfer, F-13023, found at dhs.wi.gov/forms/f1/f13023.pdf. Send the form to the address listed on the EFT form. You can also fax the form to 608-221-8185. The premium amount will be taken out of your checking account once per month.

It takes about three weeks for EFT forms to be received and processed. We will mail a letter confirming that EFT account is active.

- **Direct Payment**

If you choose to make a direct payment each month, you will receive a premium statement each month. Send your payment with the premium notice to:

Medicaid Purchase Plan
P.O. Box 93187
Milwaukee, WI 53293-0187

If you have any questions, please call 888-907-4455.

Medicaid Purchase Plan Premium Employer Wage Withholding

Instructions: Type or print clearly. Before completing this form, read the information and instructions on Page 1. Complete this form for your employee and the Member/Employer Electronic Funds Transfer form dhs.wi.gov/forms/f1/f13023.pdf, if you'd like to pay by electronic funds transfer (EFT). If you have any questions, call 888-907-4455.

Employee Information

Name — Employee (Last, First, Middle Initial)	MAPP Case Number
Social Security number — Employee	Monthly Premium Amount

You may pay the employee's MAPP Premiums by EFT or direct payment.

Electronic Funds Transfer (EFT)

If you want to pay the premium by monthly EFT, complete the Member/Employer EFT Transfer form, F-13023 (dhs.wi.gov/forms/f1/f13023.pdf).

Direct Payment

If you want to pay the premium via direct payment, send your payment, payable to Medicaid Purchase Plan (MAPP), to:
Medicaid Purchase Plan
P.O. Box 93187
Milwaukee, WI 53293-0187

Employer Information

Name — Employer	Phone Number	
Address — Employer		
City	State	ZIP Code
Signature — Employer		Date Signed

Mail completed and signed form to:

Medicaid Purchase Plan
PO Box 6738
Madison, WI 53716-0738

Fax: 608-221-8185