



CENTRAL WASHINGTON
DISABILITY RESOURCES
PAYMENT ELECTION FORM

Instructions: Please check the appropriate box in Section 1 and fill out any information in Section 2, where applicable. If paycard box is checked, skip Section 3. If paper check box is checked, skip Sections 3 and 4. If neither paycard box nor paper check box is selected, please proceed to fill out Sections 3 and 4. After entering the Financial Institution information in Section 3, please attach the required documentation as listed. Review Sections 4 and 5, then sign and date. The form must be signed and dated at the bottom in order to be considered complete. For any questions or concerns, please contact our office at (888) 623-3907.

Mail:
10425 W North Ave.
Suite 345
Milwaukee, WI 53226

Email:
CWDR@premier-fms.com

Fax:
(888) 317-3096

SECTION 1: (Check one box ONLY)

Effective Date: ___ / ___ / ___

- Input boxes for New DD Set Up, New Paycard Set-Up, Existing Paycard Set-Up, Paper Check, and Cancel DD/Paycards.

SECTION 2: (Please print clearly)

Employer Information:

Employer Name: _____ Medicaid ID #: _____

Employee Information:

Employee Name: _____ ID Number: _____

Last 4 Digits of SSN: _____ Employer Name: _____

Vendor Information:

Vendor Name: _____ Contact Number: _____

Contact person: _____ Email Address: _____

SECTION 3:

Name of Financial Institution: _____

Type of Account: [] Checking [] Savings Percentage: _____ %

FOR CHECKING ACCOUNT: Tape a voided check here. (No starter check or deposit slip.)

FOR SAVINGS ACCOUNT: Attach letter from bank with routing and account numbers. (Letter must be typed on bank's letterhead.)

