Division of Family Services
<Local DFS Office Address>
Invoice Number: **001234**
Date: **MM/DD/YY**

Case Number: **<Case #>**
<Case Name>
<Street Address>
City, State Zip>

You have been determined eligible for Medical Assistance on a spenddown basis. Your monthly spenddown amount is <$>. For the month of <month> you can start your coverage effective <date> by paying your spenddown amount to the Division of Medical Services. This amount must be received within 10 days of the date of this invoice to ensure coverage.

You will receive an invoice for your spenddown for the month of <next month> you may start your coverage by sending bills for that month to your caseworker or paying your spenddown amount to the Division of Medical Services. If you choose to pay the spenddown and do so by the 25th of this month, your coverage will be uninterrupted.

If you wish to pay in your spenddown amount, you must mail a check or money order made payable to Division of Medical Services for the full amount of <$>. Write your case number on the check or money order. Coverage cannot begin before your spenddown payment is received or you submit bills to your caseworker.

You may choose to have your spenddown amount automatically withdrawn from your bank account for future months. To request this, please complete the attached authorization form and mail it to the Division of Medical Services. It will take 30 days to process this request.

If you income or address changes, call your county Division of Family Services office to report this change. You must report any changes within ten days. The spenddown amount may change if your monthly income changes. Your Division of Family Services caseworker will notify you of any changes in your spenddown amount.

If you have questions regarding payment, call the **Premium Collections Unit** toll-free at 1-877-888-2811. If you have questions about your spenddown amount or submitting medical bills to meet spenddown, call you caseworker.

Please tear on dotted line

Please send with your payment

Case Number: **<Case>**
001234
<Case Name>
<Street Address>
<City, State Zip>

Invoice Number:

Date**: MM/DD/YY**
Amount: **<$000.00>**

XXXXXXXX 00001234 0000 01 000000

Division of Medical Services
P.O. Box 299
Jefferson City, MO 65102-0299
1-877-888-2811