**Initial Invoice**

**Division of Medical Services**
P.O. Box 326
Jefferson City, MO 65102-0326
Invoice Number: **001234**
Date: **MM/DD/YY**

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

You have been approved for **Medical Assistance for Workers with Disabilities** health care coverage. The premium amount is based on your monthly income. You requested your coverage to begin <**Title XIX Eligibility Date**>. You must pay a **<$000.00>** premium to receive this coverage. Coverage will not be available until payment is received. For future months, your regular monthly premium will be **<$000.00>** unless you have changes in your income which may affect your premium amount.

You will receive a health insurance card in the mail. If you need information about approved providers in your area, you may call the Recipient Services Unit toll free at 1-800-392-2161 or ask the providers if they accept Medicaid. Please show your health insurance card at the time you receive health care.

You must make your first premium payment by mailing a check or money order made payable to **Division of Medical Services** for the full amount of **<$000.00>**. Write the case number on the check or money order. The case number is located at the top left corner of your invoice. The premium amount of **<$000.00>** is due upon receipt of this notice and must be received before coverage can begin. Please send the attached invoice with your payment.

If you chose to have the **<$000.00>** regular monthly premium automatically withdrawn from your bank account each month on the fifteenth, it will start for your next monthly premium payment after the application is received. This amount may change if your monthly income changes. The premium amount may be from **$48 to $123**.

If you want to have your premium automatically withdrawn from your bank account each month, please fill out the enclosed authorization form and mail it to the address on the invoice. It will take 30 days to process this request.

If your income or address changes, call your county Division of Family Services office to report this change. You must report any changes within 10 days.

If you have questions regarding payment, call the **Premium Collection Unit** toll-free at 1-877-888-2811.

Please tear on dotted line Form 1stINV 11/08/02

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Please Send with your payment

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Amount: **<$000.00>**

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