Confirmation of Automatic Withdrawal

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

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

This is a reminder of your request to withdraw **<$000.00>** from your bank account. This withdrawal is for your **Medical Assistance for Workers with Disabilities** health care coverage premium payment for the month of **MM/YY**.

We will make withdrawals on the 15th of each month. If you want to stop the automatic withdrawal or if you are changing banks, please fill out the enclosed form and mail it to the Division of Medical Services, P.O. Box 326, Jefferson City, MO 65102-0326. You must give 30 days notice for processing of your request.

The premium amount may change if your monthly income changes. The premium amount may be from **$48 to $123**.

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.

Thank you,
Division of Medical Services