Automatic Withdrawal Returns

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>

We are writing to inform you that your Automatic Withdrawal was unable to be processed for the following reason:

- ❑ The account is showing Insufficient Funds. Please mail your premium payment of **<$000.00>** to the Division of Medical Services, P.O. Box 326, Jefferson City, MO 65102-0326. Write the case number on the cashiers check or money order. We will resume your automatic withdrawal for next months premium. A personal check will not be accepted.

- ❑ The account number that was supplied was incorrect. Please fill out the enclosed Automatic Withdrawal Authorization or Change form with the correct account number and mail it along with your check or money order for your premium payment of **<$000.00>** to the Division of Medical Services, P.O. Box 326, Jefferson City, MO 65102-0326. Write the case number on the check or money order.

If payment is not received in our office by <CURRENT MONTH 25TH> your Medical Assistance for Workers with Disabilities health care coverage will be discontinued.

We are writing to inform you that your Automatic Withdrawal was refunded to you for the following reason:

- ❑ Your **Medical Assistance for Workers with Disabilities** health care coverage changed to a non-premium level of care and you no longer need to pay the **<$000.00>** premium.

- ❑ Your **Medical Assistance for Workers with Disabilities** health care coverage has been closed.

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

Form RETACH 11/08/02