Special 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 were approved for **Medical Assistance for Workers with Disabilities** health care coverage with a monthly premium of **<$000.00>** effective <Title XIX Eligibility Date>. The premium amount is based on your monthly income. Your total premium for the months of <1st month through month invoice is sent> is **<$000.00>**. Please pay this amount by mailing a check or money order made payable to **Division of Medical Services**, and send it to the address on the invoice. Write the case number on the check or money order. The case number is located at the top left corner of your invoice. Please send the attached invoice with your payment.

You will receive a separate notice to pay your regular monthly premium of **<$000.00>** for the month of January 2003. As long as you pay the premium for January 2003 by the 26th of December 2002, your health care coverage will continue, even if you have not paid your premium for the months of <1st month through month invoice is sent>. If you do not pay the premium for January 2003, your coverage will end December 31, 2002.

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

Please send with your payment

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

Invoice Number: **001234**
Date: **MM/DD/YY**
Amount: **<$000.00>**

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