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>

Your spenddown amount for the month of <month> is <$>. To receive Medicaid coverage for <month> you must pay your spenddown amount to the Division of Medical Services or send your medical bills to your Division of Family Services caseworker. If you choose to pay the spenddown amount and do so by the 25th of this month your Medicaid coverage will be effective from <first of month> through <end of month>. Your Medicaid coverage will continue uninterrupted if you pay in your spenddown prior to the beginning of each month as indicated on each month's invoice.

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 your submit bills to your caseworker.

You many choose to have your spenddown amount automatically withdrawn from your bank account for future months.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 your income or address changes, call your count 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 your 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