MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION
MO HEALTHNET FOR KIDS INSURANCE PREMIUM PAYMENTS
AUTOMATIC WITHDRAWAL AUTHORIZATION OR CHANGE
(START, CHANGE OR CANCEL)

_____ _____

_____

Please allow 30 days for automatic withdrawal to start/change/cancel. When the automatic withdrawal is effective you will not receive a monthly invoice. Continue to pay the monthly invoices you receive until then. The automatic withdrawal is taken out of your account for the following month; example, June is taken out for July, etc. If you need help filling out the Automatic Withdrawal form, or to verify the effective date, call toll free at 1-877-888-2811.

☐ Start I want the Missouri Department of Social Services to withdraw the MO HealthNet for Kids Insurance Premium from my account.

☐ Change I want the Missouri Department of Social Services to change automatic withdrawal to the bank account named below.

☐ Cancel I want to cancel the automatic withdrawal of the MO HealthNet for Kids Insurance Premium.

PART A - Account Information

☐ Checking ☐ Savings

IMPORTANT:

Attach a voided personal check, savings deposit slip or a signed bank verification letter to the application form. Your name must be pre-printed on the check or savings deposit slip; starter, counter checks or bank statements are not acceptable. A bank verification letter must be signed by the bank and include your name as well as complete electronic routing and depositor account numbers. The bank verification letter must state it is for automatic withdrawal – not for a direct deposit.

PLEASE PRINT OR TYPE THE FOLLOWING INFORMATION

Name of Financial Institution _____

Address of Financial Institution (Street) _____

(City) _____ (State) _____ (Zip Code) _____

Financial Institution Telephone Number (_____) _____ – _____

Part B- Agreement

I hereby authorize the withdrawal of health insurance premiums each month from my checking or savings account with the financial institution indicated above. The automatic withdrawal is taken out of your account for the following month; example, June is taken out for July, etc. The premium amount will vary month to month based on family size and income. I understand that the amount will change annually as the premium rate changes and authorize continued automatic withdrawals. Withdrawals will be made monthly unless I choose to terminate this agreement. I understand that the MO HealthNet Division will make a reasonable effort to complete this transaction in a timely manner. I recognize that it is my responsibility to have the funds available in the account indicated above for withdrawal of my monthly premium payment.

Signature of Bank Account Holder _____ Date_____

Telephone Number (____) _____ - _____

Part C- Customer Information

Case Number __ __ __ __ __ __ __ __

Name _____

Telephone Number (_____) _____ - _____ Date _____

Signature of Case Head _____

Mail both pages of the Automatic Withdrawal Authorization form and your voided personal check or savings deposit slip or signed bank verification letter to: MO HealthNet Division, Financial Services Unit, P.O. Box 6500, Jefferson City, MO 65102-6500.