MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION
HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

DIRECT DEPOSIT APPLICATION

PLEASE TYPE OR PRINT IN BLACK INK **SEE INSTRUCTIONS ON PAGE 2**

SECTION A (PLACE A CHECK IN THE BOX OF YOUR CHOICE)

☐ **START** I request that the Missouri Department of Social Services, MO HealthNet Division deposit my Health Insurance Premium Payment Reimbursement to my bank account. I authorize my financial institution to credit the deposits to the account named below. (See Section B)

☐ **CHANGE** I request that the Missouri Department of Social Services, MO HealthNet Division change my direct deposit to the bank account named below. I authorize my financial institution to credit the deposits to the account named below. (See Section B)

☐ **CANCEL** I request that the Missouri Department of Social Services, MO HealthNet Division cancel direct deposit of my Health Insurance Premium Payment Reimbursements to my bank account.

SECTION B (COMPLETE WITH YOUR BANK INFORMATION)

(A VOIDED CHECK SHOWING THE ROUTING AND ACCOUNT NUMBERS MUST BE ATTACHED)

NAME OF FINANCIAL INSTITUTION	TELEPHONE NUMBER (INCLUDE AREA CODE)
ADDRESS (CITY, STATE, ZIP CODE)	
ROUTING NUMBER	ACCOUNT NUMBER (☐ CHECKING ☐ SAVINGS)
NAME	SOCIAL SECURITY NUMBER

SECTION C

I wish to participate in Direct Deposit and in doing so:

- I understand that in endorsing or depositing checks that payment will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State laws.
- I hereby authorize the State of Missouri to initiate credit entries (deposits) and to initiate, if necessary, debit entries (withdrawals) or adjustments for any **credit entries made in error** to my account designated above.
- I understand that the State of Missouri may terminate my enrollment in the Direct Deposit program if the State is legally obligated to withhold part of all payments for any reason.
- I understand that the State of Missouri may terminate my enrollment if I no longer meet the eligibility requirements.

SIGNATURE	DATE	TELEPHONE NUMBER (INCLUDING AREA CODE)

RETURN THIS FORM AND VOIDED CHECK TO:

MO HEALTHNET DIVISION
THIRD PARTY LIABILITY UNIT, ATTN: HIPP
P.O. BOX 6500
JEFFERSON CITY, MO 65102

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR DIRECT DEPOSIT

SECTION A

❑ **START** Check this box if you are currently on the HIPP program, or are a new participant with the HIPP Program and want the HIPP Program to direct deposit your reimbursement directly into your bank account. This process will take at least 10 days to verify your bank account. Any reimbursements made before the bank verifies your account will be by check and mailed directly to you.

❑ **CHANGE** Check this box if you are currently enrolled with the Direct Deposit, and need to close the bank account where you currently have reimbursements deposited and want the reimbursements deposited in a newly opened bank account. This re-verification of the new bank account will cause a delay in your reimbursement of approximately 10 days. Complete the form with the new account information. DO NOT CLOSE AN OLD ACCOUNT UNTIL THE FIRST PAYMENT IS DEPOSITED INTO YOUR NEW ACCOUNT.

❑ **CANCEL** Check this box if you are currently enrolled with Direct Deposit and want to cancel Direct Deposit reimbursements. If you are currently active with the HIPP program, by canceling the Direct Deposit your reimbursements will be by a check mailed directly to you.

SECTION B

Complete this information and attach a VOIDED copy of a check. Include your bank's name, address, and phone number. The electronic routing number of your financial institution is printed on the bottom left portion of your check. Your account number is also located on the bottom of your check. This is the series of digits after the routing number followed by your check number. Please print your name and include the Social Security Number of the Policyholder.

If you have any questions on this section, you may call your bank. Please remember to attach a copy of a check marked VOID across the front of the check.

EXAMPLE

POLICYHOLDER'S NAME CHECK NO. 4444
ADDRESS

PAY TO THE ORDER OF
_____

FINANCIAL INSTITUTION
CITY, STATE, ZIP
XXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXX 4444
ROUTING NUMBER DEPOSITOR ACCT NO. CHECK NO.

SECTION C

Read this agreement carefully, place your Signature on the form and return this form with your **ORIGINAL SIGNATURE** to the address listed on page 1.

OTHER

1. Attach a **VOIDED CHECK** to the front of the form within the Section B. This is necessary to verify your depositor account number, routing number and financial institution.
2. Direct deposit will be initiated after a properly completed application form is approved by the MO HealthNet Division and the successful processing of a test transaction through the banking system.
3. This form MUST be used to change any financial institution information OR to cancel your election to participate.
4. If any information completed on this form cannot be verified from the attachments or the form is completed incorrectly, the form(s) will be returned without being processed for direct deposit.