



INITIAL PREMIUM STATEMENT

Client Name and Address:

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CO	RECORD	CAT	GG	DIST
RID:				

Premium Month
Payment Due Date
Premium Amount
Total Amount Due

Eligibility Information

_____ has been determined eligible for Medical Assistance for Workers with Disabilities coverage effective _____. Your monthly premium amount has been determined to be \$ _____. Please send a check or money order for the total amount due indicated below along with the voucher in the enclosed postage paid envelope by _____. Failure to submit payment by the date provided could result in termination of Medical Assistance benefits.

Regulations and/or Law: The Ticket to Work and Work Incentives Improvement Act of 1999 (PL 106-170) and Act 2001-77 of June 2001 (P.L. 755)

Premiums for continuing Medical Assistance eligibility that are not paid may result in closing of benefits.

Retroactive Eligibility

You have been determined eligible for retroactive Medical Assistance for Worker with Disabilities coverage for the following months:

Month/Yr			
Premium			

Authorization of Medical Assistance for the Retroactive Period will be processed upon receipt of the Premium Payment.

The total premium amount for this retroactive period is \$ _____.

If you have questions about this statement, contact the Customer Service Center at 1-877-395-8930.

▲ Retain this portion for your records.

▼ Detach and return with payment in the enclosed postage paid envelope.

INITIAL PREMIUM VOUCHER

Retro	Premium Month	Payment Due Date	Premium Amount	Retro-Premium Due	Total Amount Due

- Pay online: www.humanservices.state.pa.us/MAWDOnlinePayments
- Make Checks payable to: Commonwealth of PA
- Include RID of Client on check or money order.
- Do not send cash.
- If past due amount has been submitted - Thank you.

Medical Assistance for Workers with Disabilities
P.O. Box 8052
Harrisburg, PA 17105-8052

CO	RECORD	CAT	GG	DIST
RID:				

Client Name and Address:

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Esto es en referencia a información importante sobre sus beneficios médicos. Si necesita que se lo traduzcan, comuníquese con la Oficina de Asistencia del Condado.

Tài liệu này liên quan đến tin tức quan trọng về trợ cấp chăm sóc sức khỏe. Nếu quý vị cần được giúp đỡ để phiên dịch nó, xin liên lạc với Văn phòng Giúp đỡ tại Quận quý vị cư ngụ.

Данные материалы содержат важные сведения о предоставляемом вам медицинском обслуживании. Если вам нужна помощь в их переводе, обращайтесь в Бюро помощи вашего графства (County Assistance Office).

We will give you a written notice explaining your benefits. If we deny, change, suspend, or stop benefits, we will explain the reason on the notice. You have 30 days from the date of the notice to ask for a hearing if you disagree with the action taken and/or the reasons given.