ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

COBV WAIVER REQUEST

1789 W. Jefferson St., Mail Drop 2HC6, Phoenix, AZ 85007
Email: TPLwaiver@azdes.gov • Fax: (602) 542-3396
Claims Unit, Attn: LTC BILLING DEPT

Provider Name _____ Fax No. _____

Email Address _____ Provider ID NO _____

Four Digit Code _____ Signature _____ DATE _____

NOTE: If your request has been denied you will need to submit a new waiver form and all information requested in order to process the request.

Member's Name	Assist ID	Insurance Name/MCID	Service Code	Start Date	End Date	For DDD Use Only		
						Approved	Denied	Reason
						☐	☐	
						☐	☐	
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Comments	Reason Codes
	1. Insurance not active when claim submitted. 2. Applies to deductible or payments received: waiver not needed. 3. 1500 Form needed: EOB does not show HCPC. 4. Insurance requesting action or claim correction.
	Processed By: _____
	Date: _____