

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
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: _____			

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at 602-542-0419; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. Disponible en español en línea o en la oficina local.