ARIZONA DEPARTMENT OF ECONOMIC SECURITY Division of Developmental Disabilities

REVERSAL ADJUSTMENT REQUEST COVER SHEET

ALL INFORMATION IS REQUIRED	
Provider Name (Last, First, M.I.):	Provider 4-Letter Code:
Email Address:	Phone Number:
Contact Person:	
Total Amount Reversed:	
Comments:	

I certify that the information contained in the attached request is correct and is prepared in accordance with the terms of the contract.

Provider's Signature: _____

Date:

Submit this cover sheet with the completed *DDD-1580B, Reversal Adjustment Claims Request* (Excel worksheet), and the Uniform Billing Template with the corrected claims via e-mail to <u>DDD-Claims@azdes.gov</u>.

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities Customer Service Center at 1-844-770-9500; TTY/TDD Services: 7-1-1