ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

Monthly Invoice Cover Sheet

FROM ______________________ FOUR DIGIT ALPHA CODE ______________

CONTACT PERSON ______________________ PROVIDER ID NO. ______________

PHONE NO. ______________ EMAIL ADDRESS ______________________

ADDRESS ____

CITY ______________________ STATE ________ ZIP CODE ______________

MONTH ENDING ______________ TOTAL AMOUNT BILLED ______________________

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

PROVIDER SIGNATURE ______________________________ DATE ____________

All claims should be submitted to:

Arizona Department of Economic Security
Division of Developmental Disabilities
ATTN: Business Operation Unit - Mail Drop 2HC6
P.O. Box 6123
Phoenix, AZ 85005-6123

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