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 DDD-Claims@azdes.gov.