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