

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 • 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.