Alabama Medicaid Agency
501 Dexter Avenue
Post Office Box 5624
Montgomery, AL 36103-5624

APPLICATION FOR EXTENSION OF TIME TO FILE

Medicaid Nursing Facility Cost Report

Today's Date: _____

Name of Facility (Provider): _____

Address: _____

City, State, & Zip Code: _____

Provider Number: _____ Original Due Date: _____

Cost Report Period: From: _____ To: _____

I request an extension of time until _____ to file the cost report for the facility cost report listed above. (Maximum extension period is 30 days.)

Extension Explanation: _____

_____

_____

_____

(You must give an adequate reason.)

Required Signature: _____

Full Name: _____ Title: _____

Company Name: _____

Address: _____

City, State, & Zip: _____

Telephone No.: _____ Email: _____

You may fax your extension request to Provider Audit/Reimbursement at (334) 242-0547.

Your extension request must be received prior to the cost report due date.

Alabama Medicaid Agency
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Post Office Box 5624
Montgomery, AL 36103-5624

APPLICATION FOR EXTENSION OF TIME TO FILE

Medicaid Home Office Cost Report

Today's Date: _____

Name of Home Office: _____

Address: _____

City, State, & Zip Code: _____

Original Due Date: _____

Cost Report Period: From: _____ To: _____

I request an extension of time until _____ to file the cost report for the facility cost report listed above. (Maximum extension period is 30 days.)

Extension Explanation: _____

_____

_____

_____

(You must give an adequate reason.)

Required Signature: _____

Full Name: _____ Title: _____

Company Name: _____

Address: _____

City, State, & Zip: _____

Telephone No.: _____ Email: _____

You may fax your extension request to Provider Audit/Reimbursement at (334) 242-0547.

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