# Alabama Medicaid Agency

**APPLICATION FOR EXTENSION OF TIME TO FILE**
**Medicaid Skilled Nursing Facility Cost Report**

**Email to: ProviderAudit@medicaid.alabama.gov**

Extension requests must be received prior to the cost report due date.

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: _____

(Delivery)
Alabama Medicaid Agency
Attn: Provider Audit
501 Dexter Avenue
Montgomery, AL 36104
Fax: (334) 242-0547

(USPS)
Alabama Medicaid Agency
Attn: Provider Audit
Post Office Box 5624
Montgomery, AL 36103
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