



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Medicare Hearings and Appeals
**EXTENSION REQUEST TO FILE A REQUEST FOR AN
ADMINISTRATIVE LAW JUDGE (ALJ) HEARING**

PARTY INFORMATION

Party Name *(The party seeking to appeal the CMS contractor's reconsideration determination or fair hearing decision.)*

Street

| | | |
|------|-------|----------|
| City | State | ZIP Code |
|------|-------|----------|

| | |
|------------------------------|--|
| Telephone Number () | Alternate Telephone Number () |
|------------------------------|--|

| | |
|------------------------|--------|
| FAX Number () | E-Mail |
|------------------------|--------|

| | |
|---|-------------------------------------|
| Beneficiary Name <i>(Leave blank if same as party name)</i> | Health Insurance Claim (HIC) Number |
|---|-------------------------------------|

Provider or Supplier *(Leave blank if same as party name)*

I would like to request an extension to submit my request for an Administrative Law Judge (ALJ) hearing (forms CMS-5011A/B or CMS-20034A/B) with the Office of Medicare Hearings and Appeals (OMHA) beyond the normal 60 calendar days. I understand that the ALJ has the discretion to accept or deny my request based on my good cause explanation as to why I was unable to submit my request within the 60 days. I was unable to file my request on time because:

If you have not already filed your Request for an ALJ Hearing (form CMS-5011A/B or CMS-20034A/B), please do so immediately and complete the following:

I need the time to file to be extended until: _____ / _____ / **20**_____

| | |
|-----------------|------|
| Party Signature | Date |
|-----------------|------|

PRIVACY ACT STATEMENT

The legal authority for the collection of information on this form is authorized by the Social Security Act (section 1155 of Title XI and sections 1852(g)(5), 1860D-4(h)(1), 1869(h)(1), and 1876 of Title XVIII). The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Office of Medicare Hearings and Appeals to another person or governmental agency only with respect to the Medicare Program and to comply with Federal laws requiring the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies.