

Certification & Request for Timely Filing Extension Delayed Eligibility Notification

This extension does not apply 365 days after the date of service

Alterations, additions, or deletions to the statements on this form will cause this form to be void and claim(s) will be denied.

I, the undersigned, do hereby certify that this provider was first notified of Colorado Medical Assistance eligibility for:

_____ Client Name _____ State ID Number _____

for _____ on _____
Date(s) of Service Date of Notification

I further swear and affirm that all normal and reasonable efforts to determine if the above-named client was eligible for Colorado Medical Assistance on the date(s) of service listed above were exhausted and that the result from all such efforts revealed that, prior to the date of notification listed above, no evidence of the Colorado Medical Assistance Program eligibility for the date(s) of service was found.

_____ Authorized Signature * * _____ Date Signed _____

_____ Provider Name _____ Provider Number _____

* * Signature authorization must be on file with the fiscal agent.
Must be original signature.
Photocopied signature or signature stamp is not acceptable and will result in claim denial