TA-W6837 (01/2011)

New York State Thruway Authority
Office of Traffic Management
P.O. Box 189
Albany, NY 12201-0189
(518) 471-4440

Clear Form

REPORT OF AMBULANCE SERVICE

Purpose: This form is completed by the attending Ambulance Service within 90 days from the date of service only if expenses for this call have not been submitted to and/or paid by other means, including an insurance claim. Resulting donations intend to defray, but not necessarily fully reimburse, applicant expenses.

INSTRUCTIONS:

- Complete Sections I through III.
- Submit completed signed form within 90 days from the date of service to the above address.

NOTE: The NYS Thruway Authority (Authority) reserves the right to deny requests made more than 90 days from the date of service.

Section I Ambulance Information

Ambulance Service Name	Federal ID No.

Address (Street, City, State, Zip Code)	County

Section II Call Information

Person or Agency Name Requesting Response	Date of Call	Time of Call

Reason Called

☐ Accident ☐ Illness ☐ Other _____

Interchange

Entry _____ Exit _____

Thruway Location (Check one and complete)

☐ Main Line or Section of Thruway:

Milepost _____ Direction _____

☐ Parking/Rest Area:

Milepost _____ Direction _____

☐ Service Area:

Name _____

☐ Interchange:

Name _____

Hospital (Name and Location)	Ambulance Driver Name
	Crew Leader/Attendant Name

Comments/additional information related to the incident/services provided.

List All Patients Transported in the Same Ambulance

Name	Age	Address	Date of Bill

Section III Authorization

Signature below certifies that the applicant has exhausted all other means of defraying expenses via insurance claims or any other means and, if so, will not be receiving additional payments for this request. The Authority reserves the right to deny current and future donations to any service found to be requesting donations for expenses that either could have been or have been defrayed otherwise.

_____ Authorized Representative Name

_____ Authorized Representative Title

_____ Authorized Representative Signature

_____ Date

Section IV For Authority Use Only

Service Verification Source(s)	☐ Approved ☐ Disapproved
Reviewer's Initials / Donation Amount $	_____ Director of Customer Relations / _____ Date