TA-W6837 (03/2023)

Office of Traffic Management
P.O. Box 189
Albany, NY 12201-0189
Phone No.: (518) 436-3079
Fax No.: (518) 449-3198
Email: hqtraffic@thruway.ny.gov

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 ____________________

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 Office of Traffic Management Use Only

Service Verification Source(s)

Reviewer's Initials

Donation Amount
$

Approved By: ____________________ Date: __________

Account Coding: 079200 0728SV
1001.00681.50