



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 <input type="checkbox"/> Accident <input type="checkbox"/> Illness <input type="checkbox"/> Other _____	Interchange Entry _____ Exit _____	
Thruway Location (Check one and complete)		
<input type="checkbox"/> Main Line or Section of Thruway: Milepost _____ Direction _____ <input type="checkbox"/> Parking/Rest Area: Milepost _____ Direction _____	<input type="checkbox"/> Service Area: Name _____ <input type="checkbox"/> 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)	<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved
Reviewer's Initials	_____ Traffic Program Supervisor or Designee
Donation Amount \$	_____ Date