TA-W6837 (1/2006)

New York State Thruway Authority

REPORT OF AMBULANCE SERVICE

Clear Form

Instructions: 1. All questions must be answered completely.

2. Please submit within 90 days from the date of service to:

Director of Traffic Management
New York State Thruway Authority
P.O. Box 189
Albany, NY 12201-0189

3. For Commercial Ambulance Service Only - Attach a copy of the bill for each patient listed below.

Name of Ambulance Service	Federal ID Number	Name of Official Representative

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

Called by (Toll Collector's Name & Station Number)	Called Received By (Name & Title)

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 _____ Number _____

Entry Interchange	Exit Interchange	Hospital (Name and Location)

Time of Arrival at Hospital	Ambulance Driver's Name	Attendant Name(s)

List All Patients Transported in the Same Ambulance

Name	Age	Address	Date of Bill

Comments/additional information relating to incident/services provided:

Official Representative's Signature	Date

FOR AUTHORITY USE ONLY

Service Verification Source(s):	Reviewer's Initials	Donation Amount	☐ Approved ☐ Disapproved
		$	_____ Senior Traffic Supervisor _____ Date