TA-W6837 (06/2025)

**NEW YORK STATE** | **Thruway Authority**

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

# AMBULANCE RESPONSE

***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 stipends 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: _____ | ☐ Service Area:

Milepost _____ Direction _____ | Name _____

☐ Parking/Rest Area: | ☐ Interchange:

Milepost _____ Direction _____ | 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 stipends to any service found to be requesting stipends 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)

Approved By: _____ Date: _____

Reviewer's Initials | Stipend Amount
| $

Account Coding: 079200 0728SV
1001.00681.50