PO Box 12000, Syracuse New York 13202

MAS Transportation Provider Incident Report

Check all that apply

Motor Vehicle Accident_____Medicaid Enrollee Injury_____Equipment Problem_____Medicaid Enrollee Issue _____

Date of Accident/Incident:_____Time of Accident/Incident: _____

Location of accident or incident: _____

Transportation Provider:_____Date Reported to MAS: _____

Contact Person:_____Telephone #: _____

Address:_____Fax #: _____

Driver of Provider's Vehicle:_____Driver's License # _____

Vehicle Plate #:_____Damage to Provider's Vehicle:_____Yes_____No

Detailed Description of accident/incident: (attach additional pages if necessary) _____

Check all that apply

Were emergency services called? Yes_____No_____911____Police____Ambulance___Tow truck ____

Injured: Enrollee(s)_____Driver_____Attendant_____Escort_____Other _____

Attached: Police Report_____(include agency, telephone # & report #)_____Other _____

Name:_____Medicaid #:_____Phone #: _____

Address: _____

Description of Injury: _____

Treated at: Scene_____Medical Facility_____Name Med. Facil.: _____

Brief Description of Treatment: _____

Report Submitted by:_____Phone #:_____Date:_____

_____

Print/Type Name Signature