PO Box 12000 | Syracuse, NY 13218
medanswering.com

Transportation Provider Information

Once form has been completed please fax to @ 315-299-2781 or email web_access@medanswering.com

Company Name: _____
NYS Medicaid Provider ID: _____ NPI # for Ambulance_____

Primary Contact Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____Alt Phone: _____ Fax: _____

Transportation Provider User Supervisor:_____ (This person will be responsible for managing your company user names for MAS website)

Dispatch Email: _____

Contact Email: _____

Type of Transportation Provided: Livery___ Ambulatory___ Wheelchair____ Ambulance_____

* **Please Note:** You will be required to provide documentation from NYS DOH that your company is enrolled in any of the Service Levels checked above. If you are unable to provide documentation, MAS will not be able to add you to the service you are requesting.

Boroughs of operation:

Bronx_____ Brooklyn_____ Queens_____ Manhattan_____ Staten Island_____

Hours that you will transport:

24/7 _____

or

M _____ Tu _____ W _____ Th _____

F _____ Sa _____ Su _____

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Office Hours(dispatch hours):

24/7 _____

or

M _____ Tu _____ W _____ Th _____

F _____ Sa _____ Su _____

Available for: Same Day trips_____ Next Day trips_____

Primary Source of Contact for Same Day/Next Day trips (Select One):

During office hours: Phone___ Fax___ Email____ Leave on Website_____ After Office Hours: Phone____ Fax_____ Email____ Leave on website_____

Special Instructions (anything that MAS should know about where you transport, where you don't transport, anything that will help us assign trips properly):_____

_____

_____

If, at any time, you need to make a change to the above information, please email the MAS Systems team at web_access@medanswering.com

We look forward to working with you and your company.

Signature:_____ Date:_____

Print Name:_____