



Transportation Provider Information

Once form has been completed please fax to Terri Collins @ 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 MAS User Supervisor: _____

Dispatch Email: _____

Contact Email: _____

Type of Transportation Provided: Taxi___ Ambulatory___ Wheelchair___ Stretcher___

Hours that you will transport:

24/7 _____

or

M _____ Tu _____ W _____ Th _____

F _____ Sa _____ Su _____

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_____

Counties of Operation:



PHONE 315.701.7551/800.850.5340 • P.O. BOX 12000 SYRACUSE, NEW YORK 13218 • FAX 315.299.2723

Please note for any county that you indicate below, you will need to be available for in county trips as well as long distance from the counties. If you are not willing/not available to do the in county trips, please do not mark the county as a county you will transport in. If you mark counties more than an hour away from the address listed above, you may be asked to provide additional information as to how you plan on providing safe, reliable, and on time transportation at Medicaid approved rates in those counties.

Albany___ Allegany___ Broome___ Cattaraugus___ Cayuga___ Chautauqua___
Chemung___ Chenango___ Clinton___ Columbia___ Cortland___ Delaware___
Dutchess___ Erie___ Essex___ Franklin___ Fulton___ Genesee___ Greene___ Hamilton___
Herkimer___ Jefferson___ Lewis___ Livingston___ Madison___ Monroe___ Montgomery___
Niagara___ Oneida___ Onondaga___ Ontario___ Orange___ Orleans___ Oswego___ Otsego___
Putnam___ Rensselaer___ Rockland___ St. Lawrence___ Saratoga___ Schenectady___
Schoharie___ Schuyler___ Seneca___ Steuben___ Sullivan___ Tioga___ Tompkins___
Ulster___ Warren___ Washington___ Wayne___ Westchester___ Wyoming___ Yates___

ATTENTION NEW VENDORS:

In addition to this sheet, we will also need a signed copy of the MAS Terms of Use and General Privacy policy. This can be found on our website, www.medanswering.com, under Documents and Forms under MAS Contacts and Forms, titled Terms of use. When filling this out, please include all employees that will be accessing the MAS system. All employees will need their own user name and password.

You will also need to provide MAS will a copy of your Department of health acceptance letter. The letter will include your business name, Medicaid provider Id # and service level, you were approved for.

If you have a Dba for your company, we will need to provide documentation from provider enrollment that your DBA was approved. if you do not have an approved DBA, we will be adding your company to our system with the name that is on your DOH approval letter.

We will not be able to add your company to the MAS web site until we receive all three forms, Vendor Info sheet, Terms of Use and DOH acceptance letter.

Signature: _____

Date: _____

Print Name: _____