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 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_____

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Counties of Operation:

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:

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 required forms.

Signature:_____ Date:_____

Print Name:_____