LIFE SUSTAINING EQUIPMENT FORM

For Emergency Power Needs

To be completed by Member

Name: _____ Account #: _____

Service Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____ Evening Phone: _____

The above named Member is requesting medical certification for outage priority. It is our understanding that you are currently treating:

Patient Name: _____ Date of Birth: _____

Patient Address: _____

The Patient is: ☐ the Member ☐ Spouse of the Member ☐ Parent of the Member

☐ Child of the Member ☐ Other (specify) _____

I/we hereby authorize the attending physician to release the required information to the Cooperative.

Patient/Member Authorizing Signature: _____

To be completed by Physician or Requested Home Health Care Provider

Please assist us by clarifying the facts about the patient being treated.

1. As a duly authorized medical care provider, I verify that I am currently treating _____
Name of Patient

2. The condition began on _____/_____/_____. Anticipated Length of Affliction _____

3. The patient has been diagnosed and is receiving treatment for a medical condition. As a result of that condition, it is my opinion that the patient's medical condition which will be aggravated by lack of electricity to the premises of the member a the patient therein is seriously ill or affected by a medical condition.

Please check:

☐ Life support equipment - for: _____

☐ Medical necessity - for: _____

Physician's signature: _____ Date: _____

Physician's printed name: _____ Phone #: _____

Office mailing address: _____

_____

_____

Return Completed Form To: New Enterprise Rural Electric Cooperative, Inc.
PO Box 75
New Enterprise PA 16664
Fax: 814-766-3319 Email: bmcilnay@newenterpriserec.com