# 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 as 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 By: _____

To: New Enterprise Rural Electric Cooperative, Inc.
3596 Brumbaugh Rd
New Enterprise PA 16664
Fax: 814-766-3319