

MEDICAL CERTIFICATION

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: Jay County REMC
PO Box 904
Portland, IN 47371
Fax: 260-726-6240

Please note that being included on the medical priority list does NOT insure that you will be the first to have your power restored during an outage. Nor, does it prevent you from being disconnected from not paying a past due bill, however, it does give you an additional 10 days from the disconnect date to pay your bill.