MEDICAL FORM FOR CRITICAL CARE

Member Information

DATE: _____

MEMBER NAME: _____

SERVICE ADDRESS: _____

MAILING ADDRESS (if different): _____

PHONE: _____

ACCOUNT #: _____

Secondary Contact

NAME: _____

RELATIONSHIP: _____

PHONE: _____

Completed by Patient's Physician

PATIENT'S NAME _____

PHYSICIAN'S NAME _____

PHYSICIAN'S ADDRESS _____

PHYSICIAN'S PHONE _____

TX MEDICAL BOARD LICENSE # _____

TYPE OF ELECTRIC, LIFE SUSTAINING EQUIPMENT USED: _____

MEDICAL DIAGNOSIS: _____

IS THE PATIENT/MEMBER DEPENDENT UPON AN ELECTRIC-POWERED MEDICAL DEVICE TO SUSTAIN LIFE? YES _____ NO _____

DOES THE PATIENT/MEMBER HAVE A SERIOUS MEDICAL CONDITION THAT REQUIRES AN ELECTRIC-POWERED MEDICAL DEVICE OR ELECTRIC HEATING OR COOLING TO PREVENT IMPAIRMENT OF A MAJOR LIFE FUNCTION THROUGH A SIGNIFICANT DETERIORATION OR EXACERBATION OF THE PATIENT/MEMBER'S MEDICAL CONDITION? YES _____ NO _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

PATIENT'S SIGNATURE: _____ DATE: _____

QUALIFICATIONS PURSUANT TO THIS FORM DO NOT GUARANTEE AN UNINTERRUPTED POWER SUPPLY. IF ELECTRICITY IS A NECESSITY, PATIENT/MEMBER MAY NEED TO MAKE OTHER ARRANGEMENTS. SEE TARIFF SECTION 305.E. REASONABLE EFFORT WILL BE MADE TO EXTEND THE DATE FOR DISCONTINUANCE OF SERVICE TO A DELINQUENT RESIDENTIAL MEMBER IF ESTABLISHED THAT DISCONNECTION WILL RESULT IN A PERSON RESIDING AT THE MEMBER'S RESIDENCE BECOMING SERIOUSLY ILL. PROPER DOCUMENTATION MUST BE PROVIDED AND MEMBER MAY ENTER INTO A DEFERRED PAYMENT AGREEMENT. FAILURE TO MAKE TIMELY PAYMENT AND/OR MAKE PAYMENT ARRANGEMENTS WILL RESULT IN DISCONNECTION. IF DISCONNECTED AFTER FAILURE TO REACH AN AGREEMENT OR MEET THE DEFERRED PAYMENT AGREEMENT, RECONNECTION WILL NOT BE MADE UNTIL OUTSTANDING BALANCE AND FEES ARE PAID IN FULL.

This document is valid for two years from date of document.