SouthEastern Illinois Electric Cooperative, Inc.
Medical Necessity Account Application

This application must be completed by the member and the physician to obtain Medical Necessity designation with SouthEastern Illinois Electric Cooperative, Inc.

Designation as a Medical Necessity residential member does not guarantee continuous electric service. If electricity is a necessity to sustain life, you must make other arrangements for on-site backup capabilities or other alternatives in the event of loss of electric service.

Designation as a Medical Necessity residential member does not relieve a member of the obligation to pay for electric service indefinitely. You must take steps to resolve unpaid bills to avoid service termination in the future. We encourage you to visit our website at www.seiec.com to find available programs to assist with paying energy bills.

This application must be complete and legible in order to be processed. All information is required unless otherwise indicated. This application must be renewed annually in order for your account to remain designated as a Medical Necessity residential member.

I understand that SouthEastern Illinois Electric Cooperative cannot guarantee continuous electric service and it is my responsibility to maintain on-site backup capabilities or other alternatives in the event of an unexpected loss of electric service.

I, hereby acknowledge that I have read and understand the above information.

_____ _____

Member Signature Date

PART 1: TO BE COMPLETED BY THE MEMBER – ALL INFORMATION IS REQUIRED

Member Name: *(Name on electric account)*

Patient Name: *(Name of Patient living permanently at the Service Location who requires chronic condition or critical care designation. The Patient may be the same person as the Member.)* _____

Relationship to the Member/Account Holder: _____

Account Number: *(Shown on your electric bill)* _____ Generator? ☐ Yes ☐ No

Service Location: *(Shown on your electric bill)* _____

City: **State:** **ZIP:**

Mailing Address: *(if different than Service Location)* _____

City: **State:** **ZIP:**

Member Primary Phone: **Member Alternate Phone:** *(if any)*

Emergency (Secondary) Contact Information *(Failure to Include an Emergency Contact may result in disconnection of your electric service without notice if SEIEC is unable to contact you and your electric bill is past due.)*

Name of Emergency Contact:

Mailing Address: _____

City: **State:** **ZIP:**

Phone: **Alternate Phone:** *(if any)*

Member – I certify that the information provided on this application is correct. I agree to be contacted by telephone at the phone numbers listed above with respect to the Medical Necessity Account.

Signature: **Date:**

Patient/Patient's Guardian, Parent or Managing Conservator – I hereby authorize my health care provider(s) to release the medical information included on this form to my utility to assist with the processing of this request. I understand that continuous utility service is not guaranteed and it is my responsibility to maintain a backup system or have an alternate plan in the event of a loss of utility service.

Signature: _____ **Date:**_____

You must take steps to resolve unpaid bills to avoid service termination in the future. We encourage you to visit our website to find available programs to assist with paying utility bills.

PART 2: TO BE COMPLETED BY THE PATIENT'S PHYSICIAN – ALL INFORMATION IS REQUIRED

Please Select One of the following conditions by checking one of the boxes below

☐ **Chronic Condition**

Patient suffers from an existing medical condition that will be **aggravated by the lack of utility service**.

I certify that the patient has the following medical emergency condition(s) that will be aggravated by the loss of electricity.

Condition(s):_____
_____
_____

Equipment_____ Time Period_____

☐ **Critical Care Condition**

Patient uses life supporting medical equipment at home and termination of the utility service would be **immediately life threatening.**

The following life-support system(s) or medical equipment is/are used by the patient:

Condition(s):_____
_____
_____

Equipment_____

Additional comments (if any):

Physician Name: *(Please print)*

Business Address: _____

Business Phone:

Physician Signature: **Date:**

Return completed form to:

SouthEastern Illinois Electric Cooperative, Inc.
P.O. Box 1001
Carrier Mills, IL 62917
Fax Number: 618-297-2003