Steuben Rural Electric Cooperative, Inc.

A Touchstone Energy® Cooperative
The power of human connections®

Certification of Medical Emergency or Life Support System Requiring Electricity

For Member Subject to Disconnect for Non-Payment

In cases where a medical emergency (21 NYCRR, Part 459) or a requirement for an electrically powered life support system (Cooperative Policy 320), members of the Steuben Rural Electric Cooperative, Inc. are exempt from non-payment disconnect procedures. To obtain this exemption the member may request a phone certification from their Physician. This phone certification will be valid for a period of one week. No extensions are permitted by phone. To obtain certification for more than one week, this form must be completely filled out (all questions must be answered) and signed by the Member and Physician. Periods of more than one year must be recertified annually.

TO BE COMPLETED BY MEMBER

Member Name (print):

Membership number:

Service Address:

Type of electrical equipment required:

Rated current on nameplate of equipment: _____ Amps

MEMBER CERTIFICATION AND AUTHORIZATION

I AUTHORIZE THE MEDICAL PROVIDER, _____, TO GIVE ALL INFORMATION REQUIRED TO SUBSTANTIATE MY CLAIM OF THIS EXEMPTION TO THE STEUBEN RURAL ELECTRIC COOPERATIVE, INC. I UNDERSTAND THAT THE STEUBEN RURAL ELECTRIC COOPERTIVE, INC. IS REQUIRED UNDER HIPPA TO TREAT THIS INFORMATION AS CONFIDENTIAL MEDICAL INFORMATIONAND ALLOW ACCESS ONLY TO THOSE WITH A NEED TO KNOW.

Member Signature:_____

Date:_____

TO BE COMPLETED BY PHYSICIAN:

Is this an emergency situation? If so, how long will the emergency last? A specific time of short duration is a characteristic of an emergency. Justify otherwise.

Is life support equipment required? Y / N

Duration of requested exemption: _____days, _____months

Type of electrical equipment required: _____

Rated current on nameplate of equipment: _____ Amps

PHYSICIAN'S CERTIFICATION:

Physician's Name (please print):

Address : _____

Phone Number: _____

As the above patient's physician, I certify that the above listed equipment is necessary to meet emergency (time limited) or life support needs of my patient. I also understand that falsification of this need could lead to legal action by the Cooperative.

Physician's Signature:_____ Date:_____

Mail To:
Billing Department
Steuben Rural Electric Cooperative, Inc.
9 Wilson Avenue
Bath, NY 14810
Or Fax to: (607)776-2293

Mail To:
Billing Department
Steuben Rural Electric Cooperative, Inc.
5966 South Road
Cherry Creek, NY 14723
Or Fax to: (607)776-2293