Medically Essential Service Certification

In order for Okefenoke REMC to determine whether a member is eligible for the designation as a Medically Essential Service Member, Part A must be completed by the member and Part B by the patient's physician. Return the completed form to the Member Services Department at Okefenoke REMC.

Part A: Member Application

Please type or print clearly

Date: _____

Account Number: _____ Location Number: _____

Member Name: _____ Phone Number: _____

Service Address: _____

Patient's Name (if not member) using equipment: _____
(patient must be a resident of member's home)

Does the patient have auxiliary power: Yes _____ No _____

If yes, is it battery or generator power? _____

Name & Type of equipment: _____

Physician's Name: _____

Physician's Address: _____

OREMC has fully explained how my account will be handled regarding any collection action due to non-payment of the bill. I understand that OREMC does not guarantee uninterrupted service or assign a priority status to my account for service restoration during outages. I understand that I must be prepared with backup equipment and/or power and a planned course of action in the event of power outages. I agree to notify OREMC when this equipment is no longer in use.

Member Signature: _____ Date: _____

Entered by OREMC Employee: _____ Date: _____

Notes: _____

_____

_____

Medically Essential Service Certification

Part B: Physician's Certificate

Please type or print clearly

Physician's Name: _____ Physician's License No.:_____

Physician's Address: _____

Physician's Phone Number(s): _____

I, _____ (name of physician), duly licensed and authorized to practice medicine in the State of _____, hereby certify that _____ (patient's name), who resides at _____ (patient's place of residence) and who is under my care, relies upon continuously operating electric-powered medical equipment described as follows:

_____

_____

_____

_____

The patient uses this equipment _____ hours within each 24 hour period. Following is the reason(s) in my opinion, this patient needs the continuous use of this equipment in order to sustain his/her life or to avoid serious medical complications requiring his/her immediate hospitalization: [attach additional pages if necessary]

_____

_____

_____

_____

Physician's Signature: _____ Date: _____

This certificate shall be deemed valid for a period of 12 months from the date the certificate is accepted by OREMC for purpose of determining that a member qualifies as a Medically Essential Service Member as defined by OREMC's policies and procedures, or that such designation should be renewed.