Medical Necessity Form

• The purpose of this form is to assist in determining requirements for a customer who because of medical conditions, utilizes an electrically operated medical device. Victory Electric cannot guarantee uninterrupted or continuous services, but we make our best effort to restore power outages as quickly as possible.

• If electricity is a necessity, you must make other arrangements for on-site back-up capabilities or other alternatives in the event of loss of electric service.

• Submission of this application does not automatically result in medial necessity status. Notification of the status granted will be provided to the member at the mailing address provided.

• Medical necessity status designation does not relieve a member of the obligation to pay for electric service, and service may be disconnected for failure to pay.

• Application must be renewed annually.

TO BE COMPLETED BY THE MEMBER

PART 1: All information is required

Member name:
(Name on electric account)

Patient name:

(Name of patient who is living permanently at the Service Address, and who needs critical care or chronic-condition status. The patient may be the same person as the Member.)

Service address:

City: State: Zip:

Mailing address *(If different)*:

City: State: Zip:

Account number:

Member primary phone:	Member Alternate Phone *(If any)*:

Member:
I have read and understand the information provided and certify the information on this application is correct. I understand this does not guarantee uninterrupted electrical service, does not give priority restoration in an outage, and does not prevent collections of unpaid electric bills. If electric service is critical for life support, it is my responsibility to arrange for on-site back-up capabilities or other alternatives in the event of loss of electric service.

Member Signature: Date:

Patient/patient's guardian, parent or managing conservator:
I have read and understood the information and certify that the information provided on this application about me (or the patient) is correct. I agree to the release of the information on this form concerning my (or the patient's) medical condition for the purposes stated on this application.

Patient signature: Date:

Patient name:	
Member name:	Account number:

TO BE COMPLETED BY THE PATIENT'S PHYSICIAN

PART 2: All information is required		
Option 1:	Yes	No
The patient is dependent upon an electric-powered medical device **to sustain life.**	☐	☐

–And/or–		
Option 2:	**Yes**	**No**
The patient has a serious medical condition requiring an electric-powered device or electric heating or cooling to prevent impairment of major life function through a significant deterioration or exacerbation of the person's medical condition.	☐	☐
If you answered yes to option 2, has the above medical condition been diagnosed as a life-long condition?	☐	☐

Physician name: *(printed)*	
Physician's practice name:	
Phone:	Fax:
Physician signature:	Date:

For Victory Electric Use Only:

Approved: _____ Rejected: _____ By:_____ Date: _____

After completing the application, please forward a faxed or electronic copy of the completed and signed application to Victory Electric at **620-227-8819 or 620-371-7793 or msr@victoryelectric.net**.

P.O. Box 1335 3230 N. 14th Avenue Dodge City, KS 67801
620-227-2139 800-279-7915