Heart of Texas Electric Cooperative, Inc.

CRITICAL CARE ELIGIBILITY DETERMINATION FORM

TO BE COMPLETED BY CUSTOMER

Customer Information

Name on Account: ____

Account Number: ____________________

Patient Name: ____

Service Address: ____

Telephone Number: Home_____________ Work____________________

Secondary Contact: ____

Relationship: _________________________ Phone Number: ____________________

Does customer have on-site back-up capabilities or other alternatives for loss of normal electrical service?

__________If yes, describe: ____

____

Patient's Signature: ______________________________ Date: _________________

TO BE COMPLETED BY PHYSICIAN

Physician Information

Physician Name: ____

Physician Address: ____

Physician Phone Number: ____

Medical Equipment Information

Type of Electric, Life Sustaining Equipment Used: _________________________________

Medical Diagnosis: ____

How long can patient be sustained without electrical service? ______________

Is condition life threatening without electrical service? __________________

Physician's Signature: ___________________________________ Date: __________