Tombigbee ELECTRIC POWER ASSOCIATION

1346 AUBURN ROAD ★ TUPELO, MISSISSIPPI 38804
P.O. DRAWER 1789 ★ PHONE: 662-842-7635 ★ FAX: 662-795-4261

MEMBER MEDICAL CERTIFICATION FORM
USE OF LIFE-SUSTAINING ELECTRIC DEVICE(S)

OFFICE USE ONLY

ACCOUNT NUMBER: ___________________________________ ACCOUNT NAME: ____________________________________

DATE RECEIVED: ___________________________________

PATIENT NAME: ____

PATIENT/GUARDIAN ADDRESS: ____

Medical Authorization

Physician is hereby authorized to furnish to Tombigbee Electric Power Association (TEPA), 1346 Auburn Rd, Tupelo, MS 38804, any and all information in your possession concerning the undersigned patient's physical condition, care, diagnoses, and treatment. The undersigned patient/guardian understands that treatment, payment, enrollment, or eligibility for benefits has not been conditioned on the signing of this authorization. The undersigned patient/guardian further waives all privileges and confidentiality, which may exist in the doctor/patient relationship or healthcare provider/patient relationship, so as to permit the release of all information desired by TEPA. The undersigned patient/guardian further releases you and all other persons employed by you for all claims the undersigned patient may have or claim to have for any invasion of privacy by reason of your furnishing information to TEPA. The undersigned patient further states that this medical authorization is to be considered by you to contain the core elements and required statements outlined in 45 CFR, Section 164.500, et seq. to allow you to disclose the requested information with TEPA in compliance with HIPPA Privacy Standards with respect to the disclosure of protected health information.

Date: ________________________________ ____
(Patient)

Sworn to and subscribed before me, on this the ________ day of ________________________________, 20________

Notary Public: ____________________________________ My Commission. Expires: ____________________________ (SEAL)

PHYSICIAN: PLEASE COMPLETE ALL PARTS. TEPA WILL CALL TO CONFIRM
(Type or Print all Information Below)

I am a licensed physician in the State of _________________________. The above named customer is a patient of mine and is under my care and treatment at this time. I have personally examined the above named patient within the past 90 days. The above patient is suffering from the following medical condition: ____

The length of time condition is expected to last: ____

The above medical condition requires the patient to use the following electric life sustaining device:

____

In my opinion, the termination of electrical service at the present time would result in an immediate life threatening condition for the above patient. My opinion is based upon a reasonable degree of medical certainty.

______________________________________ ______________________________________ __________________________
(Physician Signature) (Print Name) (Phone Number)

Sworn to and subscribed before me, on this the ________ day of ________________________________, 20________

Notary Public: ___________________________________ My Commission. Expires: ___________________________ (SEAL)

MEMBER'S/CUSTOMER'S ACKNOWLEDGEMENT

I have been informed by TEPA that this is only a temporary extension to pay my account and if my condition remains the same or worsens, then it is my responsibility to renew this from on or before 30 days. I acknowledge that it is my responsibility during this period to arrange for the transfer of the above patient to another location, in the event payment cannot be made. I understand that I may not request more than two (2) 30-day extensions during any 12 month period. *

I have been informed by TEPA that TEPA has the sole discretion to accept or deny this application for relief based upon a life threatening condition for the above named patient.

______________________________________ ____
(Date) (Patient/Guardian Signature)

Sworn to and subscribed before me, on this the ________ day of ________________________________, 20________

Notary Public: ___________________________________ My Commission. Expires: ___________________________ (SEAL)

***THIS CERTIFICATION DOES NOT IN ANY WAY REMOVE THE OBLIGATION TO PAY FOR SERVICES RECEIVED OR TO BE RECEIVED FROM TEPA ***