

***CRITICAL CARE ELIGIBILITY DETERMINATION FORM***

**Completion by Retailer**

ESI ID: \_\_\_\_\_

Customer Name associated with ESI ID: \_\_\_\_\_

Service Address: \_\_\_\_\_

Mailing Address (if different than Service Address): \_\_\_\_\_

\_\_\_\_\_

Date Form Sent to Customer: \_\_\_\_\_

**Completion by Customer**

Patient Name (please print): \_\_\_\_\_

Telephone Number: Home \_\_\_\_\_ Work \_\_\_\_\_

Secondary Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone Number for Secondary Contact \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Completion by Patient's Physician**

Physician Name: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Physician Phone Number: \_\_\_\_\_

### Medical Equipment Information

Type of Electric, Life Sustaining Equipment Used: \_\_\_\_\_

Medical Diagnosis: \_\_\_\_\_

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

(please mark one)                      Yes                       No

If Yes, please describe: \_\_\_\_\_

How long can patient sustain without electrical service? (number of hours) \_\_\_\_\_

Is condition life threatening without electrical service? (please mark one)                      Yes                       No

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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*This qualification requires renewal one year from the date you are qualified. The information on this form may be subject to verification and additional information may be required from you or your physician.*

**Qualification pursuant to this form does not guarantee an uninterrupted power supply, and if electricity is a necessity, you may need to make other arrangements.**