MEDICAL NECESSITY PROGRAM APPLICATION

IMPORTANT INFORMATION:

- This application must be completed to obtain Chronic or Critical Care designation with Pedernales Electric Cooperative, Inc. ("PEC").
- This application will not be processed if incomplete, unreadable, or improperly submitted. All information is required, unless otherwise indicated.
- Submission of this application does not automatically result in Chronic or Critical Care designation.
- Members will be notified upon approval and when the designation is due for renewal.
- Pursuant to the Tariff and Business Rules of PEC, designation as a Chronic or Critical Care residential member does not relieve a member of the obligation to pay for electric service, and service may be disconnected for failure to pay.
- Chronic or Critical Care designation does not guarantee continuous electric power. If electricity is a necessity to sustain life, you must make other arrangements for on-site back-up capabilities or other alternatives in the event of power loss.
- It is important that we have the most current phone number and mailing address on record. Members who have registered their PEC account(s) online may also receive notifications via the registration email address.
- More information may be found on this Program in the "Medical Necessity Program" section of the PEC Tariff and Business Rules.

INSTRUCTIONS FOR MEDICAL NECESSITY PROGRAM APPLICATION:

MEMBER: Complete Part 1 of application and provide to patient's physician to complete
PHYSICIAN: Complete Part 2 of application
MEMBER: Return signed application to any PEC office or via email, fax, or mail

Office locations: Visit myPEC.com/locations

Email: medical@peci.com

Fax: 830-868-4956
Attn: Medical Necessity Program

Mail: Pedernales Electric Cooperative, Inc.
Attn: Medical Necessity Program
P.O. Box 1
Johnson City, Texas 78636

MEDICAL NECESSITY PROGRAM APPLICATION - CONTINUED

PART 1: COMPLETED BY THE MEMBER - ALL INFORMATION IS REQUIRED

Member name on PEC account: ______________________________

Patient name: ______________________________

(Name of Patient living permanently at the Service Location who requires chronic condition or critical designation pursuant to PEC's Tariff and Business Rules. The Patient may be the same person as the Member.)

Account number on your PEC bill: ______________________________ Generator? ________

Service location on your PEC bill: ______________________________

City: ______________________________ State: ____________ Zip: ____________

Mailing address on your PEC bill: ______________________________

City: ______________________________ State: ____________ Zip: ____________

Member primary phone: ____________________ Alternate phone (if any): ____________________

Emergency (Secondary) Contact Information (Your application will be rejected unless you include an Emergency Contact name or insert "I choose not to provide an Emergency Contact name." Failure to include an Emergency Contact may result in disconnection of your electric service without notice if PEC is unable to contact you.

Emergency contact: ______________________________

Mailing address: ______________________________

City: ______________________________ State: ____________ Zip: ____________

Primary phone: ____________________ Alternate phone (if any): ____________________

MEMBER – I have read and understood PEC's information on the Medical Necessity Program and certify that the information provided on this application is correct. I understand the information may also be used to determine whether I am eligible for additional notices relating to my electric service. I agree to be contacted by telephone at the phone numbers listed above with respect to the Medical Necessity Program. Pedernales Electric Cooperative, Inc. is not liable for delayed or undelivered notifications.

PATIENT/PATIENTS GUARDIAN, PARENT, OR MANAGING CONSERVATOR – I have read and understood the information on the Medical Necessity Program and certify that the information provided in 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.

MEDICAL NECESSITY PROGRAM APPLICATION - CONTINUED

PART 2: COMPLETED BY THE PATIENT'S PHYSCIAN – ALL INFORMATION IS REQUIRED

CHRONIC CONDITION:	**YES**	**NO**
The patient has a serious medical condition that requires an electric-powered medical device or electric heating or cooling to prevent impairment of a major life function through a significant deterioration or exacerbation of the person's medical condidtion.	☐	☐
If yes to the above, has the medical condition been diagnosed as a life-long condition?	☐	☐

OR

CRITICAL CARE CONDITION:	**YES**	**NO**
The patient is dependent upon an electric-powered medical device to sustain life.	☐	☐
If yes to the above, has the medical condition been diagnosed as a life-long condition?	☐	☐

Physician name (please print): ____________________

Texas Medical Board License number: ____________________

Phone: ____________________

Physician signature: ____________________