NORTHEAST OKLAHOMA ELECTRIC COOPERATIVE

MEDICAL VERIFICATION FORM

The Oklahoma Corporation Commission (OCC) §165:35-21-10 requires electric and gas utilities under its jurisdiction to honor forms which attest to a utility consumer or permanent member of a household who uses equipment that is prescribed by a physician that operates solely on electricity and is needed to sustain the person's life. **Verification must be made by medical personnel licensed by the state. These include: Medical Doctors (M.D.), Doctor of Osteopathy (D.O.) and County Medical Directors. The Cooperative will not accept this form when it is signed by someone other than the above-mentioned licensed medical professionals. Signatures from a registered nurse practitioner (RNP), or physician's assistant (PA) will not be accepted.** You are being asked to provide verification that the need for non-battery operated equipment exists and will continue to exist for a specified period of time. Please be advised that your actions in this matter may result in this person being permitted to use utility services without immediate payment. The suspension of disconnection will allow the member to pay the account in full within 30 days of receipt of this form or enter into a payment arrangement to pay the account in full. We appreciate your willingness to participate as a verifier and trust you will do so advisedly, considering the fact that all energy consumed during this period must be paid for by the utility consumer. We want to ensure that those utility consumers having a genuine life-threatening situation in their homes are not mistaken for those who would abuse this privilege at the expense of other Cooperative members.

Examples of life-sustaining equipment: kidney dialysis machine, iron lung, oxygen concentrators and certain other oxygen machines, cardiac monitory (without battery backup), heating and air conditioning equipment or any other non-battery operated equipment prescribed by a licensed medical doctor.

MEMBER INFORMATION (Please Print)

Member Name:_____ Electric Account Number:_____

Address: _____ City: _____State:_____Zip:_____

Home Phone:_____Place of Employment:_____

Name of Resident with equipment:_____Relationship to member:_____

I do hereby acknowledge that a permanent resident of the household is applying for the life-threatening situation and I further acknowledge the financial responsibility for payment of bills rendered for electric service.

Member Signature:_____

PLEASE NOTIFY NOEC WHEN THIS PERSON MOVES FROM THE RESIDENCE OR IS DECEASED.

LIFE-THREATENING SITUATION VERIFICATION (Please Print)

Patient Name: _____

List non-battery operated equipment necessary to sustain patient's life (see above for examples):

_____

_____

PHYSICIAN SIGNATURE (Please Print)

Physician Name:_____ M.D. ☐ D.O. ☐

Address: _____ City: _____State:_____Zip:_____

Office Phone:_____Office Name:_____

Physician Signature: _____

RETURN TO NOEC:
USPS - PO Box 948, VInita, OK 74301
E-MAIL - asknoec@noec.coop
27039 S. 4440 Rd, Vinita
600 S. Main, Grove
FAX:
(918) 256-9304