MAIL OR FAX TO:
MTE Murfreesboro – PO Box 608, Murfreesboro, TN 37133-0608
FAX: 615•849•2165

Middle Tennessee Electric

LIFE SUPPORT PROGRAM – MEDICAL NECESSITY FORM

By completing this form and having a physician sign and certify that disconnection of electric service would create a life-threatening situation, MTE can enroll you in the Life Support Program. Upon verification, your individual electric account will be flagged as "life support" with an orange seal on your meter, which will keep our employees updated on your account's status. While not a guarantee of service, the program allows MTE to be especially attentive to enrolled members in the case of payment delinquency, and to some extent, outage situations.

MEMBER INFORMATION

MTE Account #: _____ Account Holder Name: _____

Patient Name: _____ Phone #: _____

Service Address: _____

City, State: _____ Zip Code: _____

I hereby confirm, acknowledge and agree that:

1. The below listed doctor may release medical information needed in order to process MTE Life Support Program enrollment and certification.

2. This medical necessity form must be completed by a medical doctor or nurse practitioner licensed to practice in the state of Tennessee certifying that the disconnection of electric service would create a life-threatening medical situationfor the member or other permanent resident of the member's household. It is the responsibility of the member to ensure that this form has been approved by MTE.

_____ _____
Signature of Member Account Holder Date

_____ _____
Signature of Patient or Guardian Date

PHYSICIAN'S CERTIFICATION

I certify that I am a licensed medical doctor and that the patient listed above is under my care, and in my professional medicalopinion, disconnection of electric service would create a life-threatening medical situation due to the following:

[Please explain illness/condition and/or the necessary life sustaining device below.]

_____

_____

I certify that the information contained herein is, to the best of my knowledge, complete and accurate and supported in the medical records of the patient. I agree to provide updates and additional details as to the specific need for electric service due to the patient's condition or treatment upon request.

_____ _____
Physician Name: (PRINT) TN License #:

_____ _____
Physician Signature Physician Phone:

☐ Processed for orange seal (For Staff Use only)

Rev: 02/2021