

# MAIL OR FAX TO:

MTE Lebanon – PO Box 220, Lebanon, TN 37088-0220

FAX: 615-449-8609



## LIFE SUPPORT PROGRAM – MEDICAL NECESSITY FROM

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 situation for 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 medical opinion, 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)

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