Date Sent: _____
Please Return Within 30 Days

MEDICAL CUSTOMER APPLICATION

IF APPROVED FOR THE MEDICAL CUSTOMER PROGRAM, A DEDICATED PHONE NUMBER WILL BE PROVIDED TO REPORT OUTAGES AND ALL ATTEMPTS WILL BE MADE TO PROVIDE UPDATES ON EXTENDED OUTAGE RESTORATION. ACCEPTANCE INTO THE PROGRAM DOES NOT GUARANTEE CONTINUOUS ELECTRICAL SERVICE NOR DOES IT PREVENT COLLECTION ACTIVITY FOR UNPAID ELECTRIC BILLS. A CUSTOMER WHOSE SERVICE IS CRITICAL FOR LIFE SUPPORT SHOULD MAKE PRIOR EMERGENCY ARRANGEMENTS TO ACCOMMODATE THE MEDICAL PATIENT DURING POWER INTERRUPTIONS. IF APPROVED FOR THE PROGRAM, RENEWAL OCCURS ANNUALLY.

TO BE FILLED IN BY CUSTOMER

_____ _____
Customer Name Account Number

_____ _____ _____ _____ _____
Street Address City & State Zip Code Home Phone Work Phone

_____ _____
Patient's Name Birth Date

Authorization: I hereby authorize release of any medical information including direct consultation with any physicians that is pertinent to my qualifying as a medical customer with Evergy Company. By signing below, applicant acknowledges the accuracy and truth of the information provided. **For your protection, the law requires you to be advised of the following:** It is a criminal act to make a false or fraudulent claim, or assist in the preparation or presentation of a false or fraudulent claim. Violators of this provision may be subject to criminal prosecution.

_____ _____
Signature of Patient or Legal Guardian Date

TO BE FILLED IN BY PHYSICIAN – PLEASE ANSWER ALL QUESTIONS

_____ Is the patient homebound? YES ☐ NO ☐
Diagnosis

Is electrically-powered medical equipment required to sustain life? YES ☐ NO ☐ What type of equipment is in use? _____

_____

Will the absence of electricity result in an immediate life-threatening situation? YES ☐ NO ☐ If so, how? _____

_____

Is the medical equipment **capable** of being operated by battery-supplied electricity for at least 12 hours? YES ☐ NO ☐

How often is the medical equipment used? _____

Have you advised your patient of the action to take in case his or her medical equipment fails to operate for any reason? YES ☐ NO ☐

If so, what is the plan of action? _____

Is the condition expected to last longer than 6 months? YES ☐ NO ☐

Additional Comments: _____

_____

_____ _____ _____
Physician's Name (Please Print) Office Address State, Zip Code

_____ (_____)_____ _____
Physician's Signature Phone Date

FOR EVERGY USE ONLY

APPROVED: ☐ REJECTED: ☐ BY: _____ DATE: _____

Revised: October 2019

Mail to: EVERGY
Attn: Medical Department
4400 East Front Street
Kansas City, MO 64120

Fax to: 816-245-3930