



LIFE- SUSTAINING EQUIPMENT CERTIFICATION

CUSTOMER INFORMATION

Member Name: _____

Address: _____

Trico Account Number: _____ Telephone #: _____

TO BE COMPLETED BY PHYSICIAN (Required information)

Please type or print

Patient's name (if different from above): _____

Patient's address (if different from above): _____

Patient's telephone number (if different from above): _____

Patient's age: _____ Date last examined: _____

Is the Patient a patient of yours? _____

How long has this individual been your patient? _____

Does this patient suffer an especially dangerous or life-threatening illness? _____

Does such dangerous or life-threatening illness require medical equipment? _____

What type of medical equipment? _____

What is the make and model of this medical equipment? _____

Is the medical equipment needed at all times? _____

If not, how much of each day is the medical equipment needed? _____

If the medical equipment requires electricity for its operation is there any reasonable substitute for electricity for its operation? _____

Is the medical equipment only required on an "as needed" basis? _____

In the event of a power outage is there an alternative power supply? _____

Is the alternative limited to batteries? _____

Is the medical equipment considered life support equipment? _____

Comments: _____

Physician's name (please print or type) _____

Physician's Address _____

Physician's Signature _____

Telephone Number _____ Date _____

Please fax completed form to Trico Electric at (520) 353-1640 or mail to address above.

NOTE: Life support equipment does not release the consumer from financial obligations. Contact Member services prior to termination date for payment arrangements.