Medical Customer Form

For AES Indiana use only		
Date Mailed:	**Date received:**	
Customer Name:	**New Application☐** **Recertification☐**	
Patients Name:	**Account number:**	
Service Address:	**Service ID:**	**Meter ID:**
City, State, Zip Code:	**Medical Alert Program Start Date:**	
Primary Phone:	**Alternate Phone:**	

NOTE: AES Indiana will update your account with the phone numbers provided

For customer use: Important information

This completed application must be returned to AES Indiana within 10 business days from the “Date Mailed.”

AES Indiana wants to ensure that its customers who require electrically powered medical equipment essential for the preservation or monitoring of health or life are not jeopardized by a misunderstanding of each one’s responsibilities. AES Indiana exercises diligence and care to maintain service to all customers. It cannot, however, guarantee uninterrupted service since electrical systems are subject to outages due to storms, equipment failure, accidents and other emergency circumstances. Only the customer knows if the condition of the patient requires uninterrupted service for the equipment in use. Therefore, if uninterrupted service is required, the customer should have an emergency back-up system or plan in place.

If a Medical Customer has difficulty paying a bill, he or she should contact AES Indiana Customer Service to determine eligibility for payment arrangements. AES Indiana will work with eligible customers to establish a

payment arrangement. However, if the customer does not fulfill the terms of any established payment arrangements, electric services can be disconnected even if you are a Medical Customer.

AES Indiana Customer Initials: _____

It is the customer's obligation to notify AES Indiana when medical equipment is no longer required outside of the terms designated and communicated via this form submission. You, as AES Indiana's customer, are in the best position to know about the removal or addition of medical equipment in your home.

Notify AES Indiana at once if changes are made in the type or use of equipment listed on this form.

Any falsification of the information provided on this form will result in ineligibility as a Medical Customer and possible disconnection of electrical service without further notice. AES Indiana reserves the right to re-verify the medical equipment. Additionally, you acknowledge that your enrollment in this program will be recertified each year.

I acknowledge receipt of the above information.

AES Indiana Customer Signature: _____

Printed Name: _____

Date: _____

Your licensed healthcare worker must complete pages 3 and 4 of this form and return to AES Indiana.

Medical Customer Form

For licensed healthcare worker's office use only

Instructions:

1. **Complete the entire form.**
2. **Return this completed application to AES Indiana (Pages 1-4)**

NOTE: This completed application must be returned to AES Indiana within 10 business days from the "Date Mailed" indicated on the front of this form.

For licensed healthcare worker's office use only

Patient's Full Name:	**Date of Birth:**	**Age:**
Patient's Permanent Address:	**City, State, Zip Code**	

Electrically powered life support equipment required at patient's permanent address:

☐ Infant apnea monitor ☐ Adult heart monitor ☐ Respirator ☐ Oxygen concentrator ☐ Nebulizer ☐ Kidney dialysis ☐ CPAP ☐ Ventilator ☐ Suction Trach Patient ☐ IV Pump ☐ VAD Device ☐ Pulse Oximeter ☐ Feeding Pumps ☐ Air Fluidized Therapy Bed ☐ Hoyer Lift ☐ Other_____

Equipment name:	**Make/Model:**
Purpose of Equipment:	
How often is equipment used:	**Is this a permanent condition?** ☐ **Yes** ☐ **No**
If this is not a permanent condition, please provide the date that the customer will no longer use the Medical Equipment (If Known):	**End Date:**

Licensed Healthcare Worker Name:	Verification phone number:
Medical Facility Address:	**City, State, Zip**
Healthcare Worker Employer Name:	
Healthcare Worker License Number:	

I certify that _____ is my patient and requires the above noted equipment to sustain his or her life and that prolonged interruption of electric service could be life-threatening. I have advised my patient and/or patient caretaker(s) to have an emergency back-up system or plan in place in the event of a service interruption.

Licensed Healthcare Worker signature: _____

Date: _____

Please return this form to AES Indiana one of the following ways:

- → Email scanned copy to: aesindianamedicalalertmb@aes.com
- → Fax copy to: 317-608-1173
- → Mail copy to:
  AES Indiana
  One Monument Circle
  Indianapolis, IN 46204
  ATTN: Medical Customer Form