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 INTERUPTIONS. IF APPROVED FOR THE PROGRAM, RENEWAL OCCURS ANNUALLY.

TO BE COMPLETED BY CUSTOMER

Evergy Customer Name (Name on Evergy Account) _____ Evergy Account Number _____ Cell/Home Phone Number _____

Street Address _____ City & State _____ Zip Code _____ Email Address _____

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 COMPLETED BY PHYSICIAN – PLEASE ANSWER ALL QUESTIONS

Diagnosis _____ Is the patient homebound? Y N

Is electrically-powered medical equipment required to sustain life? Y N

Please circle the type of equipment used: Apnea Monitor Airway Suctioning Device Dialysis (all types) Ventilator

Other (please provide equipment name) _____

Is the medical equipment capable of operating by battery-supplied electricity for at least 12 hours? Y N

How often is the medical equipment used? _____

What back-up plan of action has been advised to the patient in case his or her medical equipment fails to operate for any reason?

_____

Is the condition expected to last longer than 6 months? Y N

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

Physician's Signature _____ Phone _____ Date _____

FOR EVERGY USE ONLY

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

Mail To: EVERGY
Attn: Medical Department
4400 East Front St
Kansas City, MO 64120

Fax To: (816) 245-3930