EVERSOURCE

MEDICAL CERTIFICATION OF ILLNESS FORM FOR EVERSOURCE RESIDENTIAL CUSTOMERS

To be completed by a Registered Physician, Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA).

Eversource will provide protection from a service shut-off if a Registered Physician, Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA), certifies the patient listed below is **seriously ill,** has a **life-threatening situation,** or **qualifies for infant protection**. See Conn. Agencies Regs. § 16-3-100.

Please review the classifications listed below and select the one that best describes your patient's condition.

☐ **Serious Illness:** My patient is seriously ill. However, not having gas or electric service ***will not*** endanger the life of my patient. The household is protected from a service shut-off for nonpayment between November 1 and May 1.

☐ **Life-Threatening:** My patient has a medical condition and not having gas or electric service ***will*** endanger the life of my patient. The household is protected from a service shut-off for nonpayment year-round.

☐ **Infant Protection:** Patient is a child under the age of two who is discharged from the hospital and needs utility service for health and well-being. The household is protected from termination for nonpayment until the protection expires or the child turns two years old.

Does the life-threatening situation require the use of electrically operated equipment? ☐Yes ☐No

(Not required for certification; needed solely for purposes of reconnection during an outage)

Please select the length of the serious or life-threatening situation.

☐ **1 month or less** ☐ **1-3 months** ☐ **3-6 months** ☐ **6-9 months** ☐ **9-12 months**

This form must be completed every 15 days if no length of illness is specified and must be recertified at least annually. Patients should contact their utility to enter into a payment arrangement to pay their utility bills.

*Patient's Name: _____ *Utility Account Number: _____

*Patient's Address: _____

*Physician/PA/APRN's Name: _____

Physician/PA/APRN's Address: _____

*Physician/PA/APRN's Telephone Number: _____ Fax Number: _____

*Physician/PA/APRN's Signature: _____ *Medical State License #: _____

*Date: _____

*** Information required to process certification form.**

Please return the completed form by fax or mail to Eversource within seven (7) days of receipt.

Eversource Energy c/o Credit & Collections
1985 Blue Hills Ave Ext.
Windsor, CT 06095

Telephone: 1-800-286-2828
Fax: 1-800-238-4067

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CUSTOMER INFORMATION

If different from patient information:
Utility Account Holder's Name: _____

Street Address: _____

State: _____ Zip Code: _____
Customer Telephone Number: _____

CUSTOMER AUTHORIZATION

I authorize Eversource to certify with my Registered Physician, Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA), that my medical condition is a serious illness or life-threatening situation.

Patient, Guardian or Conservator's Name (Print): _____

Patient, Guardian or Conservator's Signature: _____

The utility has the right to contest the validity of any Medical Certification of Illness form before the Public Utilities Regulatory Authority. See Conn. Agencies Regs. § 16-3-100 (e) (1) and (e) (5).

During outage events, if you provide us with information regarding life support equipment operating at a service address, municipal authorities will be provided with the service address where such equipment is operating. This information is shared consistent with state regulations.