HUNTSVILLE UTILITIES
ELECTRICITY • NATURAL GAS • WATER

CRITICAL CARE LIST APPROVAL REQUEST

Account Holder Instructions: Please complete the below information regarding your Huntsville Utilities account.

Account Holder Name: _____ **Account #:** _____

Account Holder Address and Phone #: _____

Account Holder Email Address: _____

I understand by being added to the Critical Care List, for the below listed patient, I will be subject to the normal Billing & Collection procedures and may be subject to disconnection due to non-payment of the monthly utility bill. I also understand I am responsible for arranging emergency backup devices for medical equipment in the event of a service outage or disconnection due to non-payment.

Account Holder Signature: _____ **Date:** _____

Medical Establishment Instructions: The following is to be completed by a licensed medical professional and only after you, or someone in your office, has examined the individual whose name appears as the patient below. This form applies only in situations where, in your professional opinion, terminations of utility services would be especially dangerous to the health of that individual. If, in your professional opinion an especially dangerous situation does not exist, please do not complete this form.

Please print the following:
I certify that my patient has been examined by me and I have determined the following to be true:

Name of Patient: _____ **Patient's DOB:** _____

Patient's permanent residence (street address): _____

City, State, ZIP, Phone #: _____

Caregiver Name and Phone # (if applicable): _____

Please check the applicable condition that applies to the patient listed above:

- ☐ Children (under five years old) on APNEA MONITOR
- ☐ CONTINUOUS--Invasive or Non-Invasive--VENTILATION DEVICE. Oxygen only does not qualify.
  ICD10 Code: _____ Device: _____
- ☐ HOME HEMODIALYSIS UNIT
  ICD10 Code: _____ Device: _____
- ☐ OTHER: _____
  ICD10 Code: _____ Device: _____

I certify that, to the best of my knowledge, the information provided above is true. I also certify that I have advised my patient that disclosure of the requested information may be subject to re-disclosure to Huntsville Utilities and may no longer be protected by HIPPA rules and regulations.

Authorized Signature: _____ **Date:** _____

Name of licensed medical professional: _____

Business address/phone #: _____

Current State License or Certificate Number: _____

If you have questions regarding this form, please contact Huntsville Utilities at 256-535-1200.
You may fax the completed form to us at 256-535-1437

256.535.1200
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Huntsville, AL 35801