MEDICAL CUSTOMER FORM

For AES Indiana use only

Date mailed:	Date received:	

Customer name: Rachel Poole	■ New application	☐ Recertification
Patient's name:	Account number: 200000561687	
Service address: 2238 N Catherwood ave	Service ID	Meter number
	7000102306	1093954
City, State, Zip: INDIANAPOLIS,IN 46219	Medical alert program effective date	
Primary phone: 3174966147	Month	Day / Year
Alternate phone:	12	05 / 2024

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

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.

I acknowledge receipt of the above information.

AES Indiana customer signature	Printed name	Date

Your physician's office must complete the back side of this form and return to AES Indiana.

AES Indiana Customer Service: 317.261.8222

AES Indiana Emergency Lights Out: 317.261.8111

aes Indiana

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For physician's office use only

Instructions:

1 Complete this entire page.

2 Return this completed application to AES Indiana (Pages 1 and 2)

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.

Select the most convenient method to return this form to AES Indiana:

Email scanned copy to:
aesindianamedicalalertmb@aes.com

Fax copy to: 317-608-1173

Mail copy to: AES Indiana
2102 N. Illinois Street
Indianapolis, IN 46202
ATTN: Medical customer form

Patient full name:	Date of birth: (MM/DD/YYYY)	Age:
Patient's permanent address:		Apt #:
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 ☐ Other (describe):

Equipment name:	Make/Model:
Purpose of equipment:	
How often is equipment used:	Is this a permanent condition? ☐ Yes ☐ No
If not a permanent conditions, duration date of prescribed term:	

Physician's name:	Phone:
Physician's address:	City/State/Zip:
Physician's 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.

Physician's signature: _____

Date: _____

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