Medical Certification Form

Please ask your health care provider to complete this form and send it with a cover letter on official letterhead via fax 217.424.6496 or email amerenilcredit@ameren.com.

Patient's Ameren Illinois Account Number: ____ ____ ____ ____ ____ - ____ ____ ____ ____ ____

Name(s) on Account: _____

Patient's Name: _____ Date of Birth: _____

Patient's Street Address (not the mailing address):

_____

Address Apt #, Unit #, or Other

_____

City State ZIP

Patient's Phone Number (__ __ __) __ __ __- __ __ __ __ or

Email Address_____

Does the Patient reside at the above address: ◯ Yes or ◯ No

Loss of Electric ☐ and/or Gas ☐ service will aggravate an existing medical emergency or create a medical emergency for the patient.

Provider Name (please print): _____

Provider Type: ◯ Physician ◯ Physician Assistant ◯ Nurse Practitioner ◯ Registered Nurse

Provider Address:

_____

Address City State ZIP

Physician or Health Official Phone Number:
(__ __ __) __ __ __- __ __ __ __

Today's Date:

Provider's Signature: _____ ____/____/____

By signing this document, I certify the patient residing at the above address requires the use of electric and/or gas service at all times. In addition, loss of electric and/or gas service will aggravate an existing medical emergency or create a medical emergency for the patient.