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: _____

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.

Physician or Health Official Name (please print): _____

Physician or Health Official Address:

_____

Address City State ZIP

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

Signature of physician or health official: Today's Date:

_____ _____/_____/_____

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.