Medical Hardship Checklist

Ameren Missouri offers medical hardship for customers or occupants of a residence with an illness that may or may not require medical equipment. A medical hardship allows a reprieve from disconnection until the next disconnection date. An account may be granted one medical hardship within a 12-month period.

INSTRUCTIONS:
For an account to be considered for a medical hardship, a letter must be faxed from the patient's physician to 1.314.259.3116. **The letter must meet the requirements listed below.** Once the physician's letter is reviewed, if all qualifications are met, the account will be removed from threat of disconnection for the current billing cycle only.

NOTE: Our Medical Equipment Registry Desk will contact you **24-48 business hours** after receiving your letter. Additional information may be required upon request.

THE LETTER MUST MEET THE FOLLOWING REQUIREMENTS:

- The name and address of the ill person along with the Ameren account number associated with the address.
- A phone number where you can be reached for any questions or follow-up.
- The reason for the medical hardship (diagnosis).
- The letter must be on the physician's letterhead and signed by the physician or nurse practitioner.
- The letter **MUST** be faxed from the doctor's office. We will NOT accept a fax from another source.
- The medical hardship documentation must be received within 24 hours of service being disconnected.

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 314.259.3116.

Patient's Ameren Missouri 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: (_____) _____ - _____

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.

Medical Condition: _____

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:
(_____) _____ - _____

Provider's Signature: _____ 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.

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