**wiIt V INSTRUCTIONS:** The customer should fill out the “**CUSTOMER**” section of the form, and the health care provider should fill out the “**HEALTH CARE PROVIDER**” section, or the health care provider may complete an online version of the form on Eversource’s secure online site, www.eversource.com/MDform. Eversource will reject forms without the health care provider’s signature. Please return the completed form to Eversource by mail to Eversource, Attn: Credit Department, P.O. Box 330, Manchester, NH 03105, or by fax to (603) 634-3474. If you have any questions, please contact Eversource at 1-844-273-7760.

**CUSTOMER**

**A medical emergency certification does not protect you from disconnection of your electric service unless you make and comply with a payment arrangement for any past-due balances** (NH Code of Administrative Rules PUC 1205.03). Even with a medical emergency certification, you should be prepared to respond to power outages. The certification, once accepted, is valid for no more than one year from the date it is received by Eversource. It is your responsibility to renew your medical emergency certification before it expires.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date | | **Name of Eversource Customer of Record *(Required)*** | | | Phone Number ( ) |
| **Patient Name (if different from Customer of Record) *(Required)*** | | | | | |
| **Customer Service Address *(Required)*** | | | | | **City *(Required)*** |
| **State *(Required)*** | **Zip *(Required)*** | | Email | Eversource Account Number (9 digits)  56- | |
| Name of 3RD Party Contact (Optional) | | | | | Phone Number  ( ) |

*I hereby authorize the release of the medical information necessary for the completion of this form.*

|  |
| --- |
| Customer Signature Date |

**HEALTH CARE PROVIDER**

NH Code of Administrative Rules PUC 1205.02 protects a utility customer from disconnection of electric service when the customer is complying with a payment arrangement for a past due balance and a physician, advanced practice registered nurse, physician’s assistant or mental health practitioner (“health care provider”) certifies that a medical emergency exists. **A medical emergency exists when disconnection of electric service creates a danger to the physical or mental health of a customer or a member of the customer’s household** (PUC 1202.11).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Health Care Provider’s Name *(Required)*** | | | **License Number *(Required)*** | |
| Address | | | | City |
| State | Zip | Email | | Phone Number ( ) |
| **Description of Patient’s Medical Condition and the Danger that Would Result if Utility Service Were Disconnected *(Required)*** | | | | |
| **Anticipated Duration of Condition (No More Than 12 Months) *(Required)*** | | | | |

**I hereby certify that, according to my records, the Patient resides at the Customer Service Address and that the Patient has a physical or mental health condition which would become a danger to the patient’s physical or mental health should utility service be disconnected.**

|  |
| --- |
| **Health Care Provider’s Signature *(Required)*** Date |