CENTRAL MAINE POWER

An AVANGRID Company

Central Maine Power Company
Customer Relations Center
83 Edison Drive, Augusta, ME 04336
800.750.4000 or (fax) 207.629.2195

Certificate of Medical Equipment Necessity

PLEASE COMPLETE AND SIGN FORM

Account/Patient Information

CMP Account Number			
Billing Name on Acct (First/Last)			
Service Address		City	
Mailing Address		City	
Phone Number	( ) -		
Patient Name (First/Last)			
Patient Address		City	
Physician Name (First/Last)			
Physician Address		City	
Physician Phone Number	( ) -	Physician Fax Number	( ) -
Subsidized Housing?	☐ Yes ☐ No		

Medical Equipment Information (To be Completed by Physician)

Please complete if **life sustaining medical equipment** is currently in use to treat a medical condition that requires electrical service for regular operation which exceeds 30 days and/or is generally considered to be long term in nature.

Type of medical equipment _____

Your signature confirms that medical necessity equipment exists within the household of the patient listed above and the loss of electrical service would likely impair the operation of such equipment.

Signature of Physician or Physician's Agent/Designee _____

Printed Name/Title (if signed by person other than the Physician) _____

Date _____

Oxygen Pump Information (To be Completed by Physician)

If the patient is currently using an **oxygen pump**, please complete the following:

Date patient began using oxygen pump _____

Number of hours used per day _____

Anticipated duration that patient will use oxygen pump _____

I certify that it is necessary for the patient identified above to use an oxygen pump for the number of hours indicated per day and for the length of time specified.

Signature of Physician or Physician's Agent/Designee _____

Printed Name/Title (if signed by person other than the Physician) _____

Date _____

OFFICE USE ONLY

CUSTOMER CONTACT CENTER:

☐ SAP ☐ Confirmation Letter and Fact Sheet

SERVICE CENTER:

☐ SAP