

BOARD OF LIGHT AND POWER  
Physician's Certification Form For  
Medically Necessary Life Support Device

In its electric rate schedule, Grand Haven Board of Light and Power (Board) has a rate for customers utilizing electricity for medically necessary life support devices. The rate schedule requires a physician's certification that the patient is dependent on an electrically operated device for continuing life support. The intent of this provision is to exempt a customer from paying a higher kilowatt-hour charge because of a life support device that consumes a large amount of electric energy.

In certifying this patient, these guidelines should be followed:

1. The device should be medically necessary to support the patient's life on a continuing basis. These are presumed to be such devices as respirators and kidney dialysis machines.
2. Normally, items incidental to the patient's comfort or mobility are not considered as life support devices. This would normally exclude air conditioners, electronic air filters, pool heaters, whirlpools, rocking beds, medicine refrigeration equipment and electric wheelchairs. Certification of such devices may require further investigation by a Board-approved physician.
3. The device should consume a reasonable amount of energy. For example, certain monitors may be considered life support in nature but they use so little energy as not to be a burden on the patient financially. Certification of such devices may require further investigation by a Board-approved physician. The Board reserves the right to accept or reject customers on the life support provision that utilize devices with minimum kWh consumption.
4. The Board has not given blanket certification to any particular device or manufacturer. Certification is for a specific patient and specific device.

PHYSICIAN'S CERTIFICATION

I certify that:

\_\_\_\_\_  
(Patient's Name)

\_\_\_\_\_  
(Patient's Phone Number)

\_\_\_\_\_  
(Patient's Address)

\_\_\_\_\_  
(City, State, Zip)

Requires the use of a \_\_\_\_\_ for treatment of \_\_\_\_\_ as a medically necessary life support device in accordance with the above guidelines.

Signature of Physician \_\_\_\_\_

Phone (    ) \_\_\_\_\_

Name \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

BLP Account No. \_\_\_\_\_