Date: [Date]

To: [Utility Company Name]
Department: Medical Emergency/Life Support Desk
Address: [Utility Company Address]

RE: MEDICAL NECESSITY FOR UNINTERRUPTED SERVICE

Account Holder Name: [Name on Bill]
Service Address: [Full Service Address]
Account Number: [Utility Account Number]

To Whom It May Concern,

This letter serves as formal medical certification that the patient residing at the address above, **[Patient Name]**, is medically dependent on electricity-powered equipment for life-sustaining treatment.

Medical Condition: [Brief description of condition, e.g., COPD, Respiratory Failure]
Required Equipment: [e.g., Oxygen Concentrator, Ventilator, CPAP/BiPAP]
Usage Frequency: [e.g., 24 hours per day / Continuous]

The aforementioned equipment requires a continuous and reliable supply of electricity. A loss of utility service would constitute a life-threatening emergency for this patient.

Please update your records to include this household on your "Priority Service" or "Life Support" registry. We request that you provide advance notification of any planned power outages and refrain from disconnecting service for non-payment without first coordinating with the patient's medical providers or emergency services.

This medical necessity is expected to last for: [Duration, e.g., Indefinitely / 12 months].

If you require further medical documentation or have specific forms for your registry, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical Facility Name]
[Medical License Number]
[Phone Number]