Exhibit No. 106

Ameren – Exhibit 106
Medical Equipment Registry Form
File No. EC-2024-0111

Medical Equipment Registry Application

By completing this form, the account noted below will be added to Ameren Missouri's Medical Equipment Registry so you receive advance notice of planned outages and can make alternate arrangements for use of your medical equipment. Please note that since many conditions beyond our control can result in outages, we cannot guarantee uninterrupted electric service. We recommend that you develop an alternate plan and have a backup device or a standby power source to accommodate your medical needs.

Completion of this form does NOT prevent disconnection of electric service for nonpayment and does not provide priority restoration of utility service following an outage. **IF THIS FORM IS RETURNED INCOMPLETE OR WITH INCORRECT INFORMATION, IT WILL BE RETURNED AND POSSIBLY DELAYED.** For any questions, contact us at **HealthAndSafety@Ameren.com**.

CUSTOMER INFORMATION

(To be completed in its entirety by the customer of record at the listed address.)

Customer Name: _____ Account #: _____

Service Address: _____

Patient Name: _____ Date of Birth: _____

Relation to Customer of Record: _____

☐ *I hereby authorize my provider to provide the information below to Ameren Missouri in reference to use of electrically operated medical equipment in my home.*

PROVIDER'S STATEMENT

(To be completed in its entirety by attending provider. Must be a physician/physician's assistant/nurse practitioner/hospice nurse.)

Provider Name: _____ Phone #: _____

Provider Type: ☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner ☐ Hospice Nurse

Health Care Group Affiliation: _____

Patient Diagnosis/Condition: _____

Indicate below the type of electrically operated medical equipment:

☐ Oxygen concentrator ☐ Anesthesia machine ☐ Suctioning device ☐ Heart monitor ☐ Dialysis (all types)

☐ Home kidney dialysis ☐ BiPAP (Bilevel Positive Airway Pressure) ☐ IV and nutrition pumps ☐ Apnea/Bradycardia monitor

☐ Apnea monitor ☐ CPAP (Child) ☐ Home kidney (Peritoneal Cycler) dialysis ☐ IPPB respirator ☐ Respirator

☐ Oxygen concentrator ☐ Suction machine ☐ Ventilator ☐ Other _____

How often is the device used? _____

Provider's Signature: _____ **Date:** _____

Ameren Missouri
P.O. Box 66149, Mail Code 330
Saint Louis, MO 63166-9989

1.800.552.7583 (Phone)
1.314.259.3116 (Fax)

Other Services
Speech & Hearing Impaired Phone: **711** or **1.800.735.2966**
Visually Impaired and Interpreter Service Phone: **1.800.552.7583**