



MRI Access Fund Application

706 Haddonfield Road, Cherry Hill, NJ 08002

(800) 532-7667, ext. 120

Web: www.mymsaa.org; Email: mri@mymsaa.org

What is the MSAA MRI Access Fund?

The MSAA MRI Access Fund assists individuals who are uninsured or under insured acquire a cranial magnetic resonance imaging (MRI) exam to help determine a diagnosis of multiple sclerosis or evaluate current MS disease progression. MSAA will work with eligible individuals, physicians, imaging centers and insurers to help fund the necessary MRI.

What services are provided through the MRI Access Fund?

Insurance payment assistance: For those of low/moderate income who have medical insurance (including Medicare) and are not able to meet the co-payment or co-insurance, the MRI Access Fund will assist in covering the remaining balance of the MRI.

Full payment: For those of low/moderate income who do not have medical insurance or cannot afford their insurance deductible, the MRI Access Fund will pay for the MRI through contracted imaging centers across the country.

Who is eligible?

Individuals who:

- Are suspected of having multiple sclerosis and need an MRI to help confirm a diagnosis
- Have multiple sclerosis and need a follow-up MRI to track disease progression
- Meet income eligibility guidelines (Step 1 of this application)

Applicants must:

- **Complete Steps 1 – 5 of this application and return it to MSAA**
- **Receive approval from MSAA prior to having an MRI (no reimbursements provided)**
- **Seek Cranial MRIs only (no cervical spine, lumbar and thoracic spine MRIs)**
- **Submit all necessary bills to MSAA in a timely manner**

Important Notes:

- **Each applicant will receive one (1) MSAA-funded MRI exam within a 24-month period.**
- The program does not cover any additional costs such as doctor visits, reading or lab fees.
- Incomplete applications will be returned to the client for completion and may delay processing.
- Applications are processed on a first-come, first-served basis. No emergency situations apply.
- Qualified clients not using their insurance for an MRI must go to a MSAA-contracted facility.

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Step 1: INCOME ELIGIBILITY FORM

Name: _____ Phone: (____) _____ Date: _____

Address: _____

Part A. YEARLY FAMILY INCOME is defined as all earned wages and other reported income (i.e. disability, pension, alimony, child support, etc.) from last calendar year for the person with MS **and** his or her spouse or partner living in the home.

My Yearly Family Income is: \$_____.

The total number of people living in my household is: _____.

Part B. Based on the information above, check the chart to see if your income is below the listed amount. If so, proceed to Part C and continue the application.

Example: Mary Smith has MS. She lives with her husband and daughter. Thus, there are 3 people in the household. Mary and her husband's combined Yearly Family Income is \$52,000. This is less than \$60,270 listed on the chart for a family of three, so she qualifies.

MSAA's Yearly Family Income Guidelines (based on 3x the federal poverty level)

Persons living in the Household	Income
1	\$35,310
2	\$47,790
3	\$60,270
4	\$72,750
5	\$85,230
6	\$97,710
7	\$110,190
8	\$122,670

Part C. Please Sign Below:

By my signature below, I (the applicant) hereby certify that the information provided to MSAA is true and accurate to the best of my knowledge. I also understand that MSAA has the right to request written income verification if needed and/or deny this application if the required information and signature are not provided or the income exceeds our limits.

Signature: _____

Date: _____

Guardian: _____

Date: _____

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Step 2: PERSONAL DATA FORM

I am an individual:

☐ Diagnosed with MS ☐ Not diagnosed but suspected of having MS ☐ Diagnosed with CIS

Information on the person seeking an MRI

Name: _____

Address _____

City

County

State

Zip

Date of Birth _____ ☐ Female ☐ Male Marital Status _____

Home Phone _____ Cell Phone _____

Email address _____

If under 18-years-old, name of the patient's parent or guardian: _____

Relationship to patient: _____

Ethnic Origin (optional)

☐ American Indian or Alaska Native

☐ Hispanic or Latino

☐ Asian

☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American

☐ White or European

☐ Chicano or Mexican American

☐ Other (please specify) _____

How did you learn about MSAA?

☐ Neurologist

☐ Family/Friend

☐ Primary Care Physician

☐ MSAA Client

☐ Other Healthcare Providers

☐ MSAA Activity

☐ Social Services Professionals

☐ MSAA Publication

☐ Other MS Organizations

☐ MSAA Motivator magazine

☐ Pharmaceutical Company

☐ Media

☐ Internet

☐ Do not recall

Please continue on next page

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Step 2: PERSONAL DATA FORM continued

For individuals with MS only, please complete the following:

MS Classification: ☐ Benign ☐ Secondary Progressive ☐ Primary Progressive
☐ Relapsing/Remitting ☐ Progressive Relapsing ☐ Unclear diagnosis

Year Diagnosed: _____

Other Conditions: _____

Wheelchair Use: ☐ None ☐ Occasional ☐ Moderate ☐ Always

Assistive Devices: ☐ Cane ☐ Crutches ☐ Walker ☐ Scooter
☐ Other: _____

Symptoms

<input type="checkbox"/> Fatigue	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Depression	<input type="checkbox"/> Headaches
<input type="checkbox"/> Tingling		<input type="checkbox"/> Balance Difficulty	<input type="checkbox"/> Speech
<input type="checkbox"/> Numbness	<input type="checkbox"/> Difficulty with	<input type="checkbox"/> Coordination Loss	<input type="checkbox"/> Swallowing
<input type="checkbox"/> Burning Sensation	Problem Solving	<input type="checkbox"/> Leg Heaviness	<input type="checkbox"/> Heat Sensitivity
<input type="checkbox"/> Pain	<input type="checkbox"/> Bladder issues	<input type="checkbox"/> Weakness	<input type="checkbox"/> Cold Sensitivity
<input type="checkbox"/> Muscle Spasms	<input type="checkbox"/> Bowel issues	<input type="checkbox"/> Tremors	<input type="checkbox"/> Other Symptoms
<input type="checkbox"/> Muscle Tightness	<input type="checkbox"/> Vision Loss/Blur	<input type="checkbox"/> Dizziness/Vertigo	

Tests you've had: ☐ MRI Brain ☐ MRI Cervical Spine ☐ Spinal Tap ☐ Evoked Potentials

Are you currently taking a disease modifying therapy (DMT) for MS? ☐ Yes ☐ No

DMT you use: ☐ Aubagio® ☐ Avonex® ☐ Betaseron® ☐ Copaxone® ☐ Extavia® ☐ Gilenya
☐ Lemtrada® ☐ Novantrone® ☐ Plegridy® ☐ Rebif® ☐ Tecfidera® ☐ Tysabri®

Are you currently involved in a clinical trial? ☐ Yes ☐ No

If yes, please list location: _____

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Step 2: PERSONAL DATA FORM continued

For all applicants, please provide your insurance information as directed below.

At present, I am ...

- ☐ receiving private insurance ☐ receiving Medicare ☐ receiving Medicaid
☐ waiting for private insurance. List month/yr. you expect to have insurance: _____
☐ without health insurance.

Have you enrolled in the Health Insurance Marketplace? ☐ Yes ☐ No

If no, please explain: _____

For information on the Affordable Care Act, please visit www.healthcare.gov or call 800-318-2596.

Insurance Provider: _____

Phone: () _____ ID card #: _____

IF POSSIBLE, PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD.

Important Insurance Terms

Deductible: your out-of-pocket healthcare costs, before insurance will pay for expenses.

Co-insurance: your share of the costs; a percentage after meeting your deductible.

Co-pay – a pre-determined amount you pay (ex: doctor visit for \$20).

Do you have a deductible? ☐ Yes ☐ No

If yes, please list your: **Deductible:** \$ _____ and **Balance:** \$ _____

What is your insurance co-insurance?

☐ 100% ☐ 80%/20% ☐ 70%/30% ☐ Other – please indicate _____

Do you have secondary insurance? ☐ Yes ☐ No

Insurance Provider: _____

Phone: () _____ ID card #: _____

Has your insurance denied your MRI exam? ☐ Yes ☐ No

I hereby authorize MSAA to contact my insurance provider to obtain insurance information used to determine my eligibility for the MRI Access Fund.

Client Signature _____ Date _____

Signature of Guardian _____ Date _____

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Step 3: TERMS AGREEMENT FORM

By signing this agreement, I do hereby certify that the information I have provided to MSAA is accurate to the best of my knowledge, and I do not have sufficient insurance or financial means to provide full payment for an MRI exam. By signing this agreement, I do hereby agree to the following terms and conditions as set forth by the **Multiple Sclerosis Association of America (MSAA)**.

1. If MSAA needs to verify the information that I have provided (including my statement of family income), then I will grant permission in writing to MSAA to review my physician records, imaging center records, tax records, and insurance records.
2. I hereby authorize the MSAA to contact my health care provider, insurance company, or other third party payers and for such parties to release to the MSAA all medical records, insurance, or third party payer information which is to be used to assist in determining my level of eligibility for the service of the MRI Access Fund.
3. I understand that any payment will be made directly to the imaging center.
4. I understand that I am responsible for paying any additional fees such as lab fees and physician fees for reading the test and any unpaid portion of the MRI not covered by the MRI Access Fund and this terms agreement.
5. I release and hold harmless the **Multiple Sclerosis Association of America, Inc.**, and the supporters of the MRI Access Fund and their respective officers, employees, agents, funders and members for any resulting adverse effects of the test and/or resulting treatment.
6. I understand and agree that the personal and medical information I have voluntarily provided to MSAA may be used or shared for the sole purpose of acquiring the service or benefit I have requested. I understand MSAA's policy is to strictly maintain the confidentiality and security of all personal information.
7. I agree to comply with MSAA requests for follow-up correspondence and submission of necessary billing information in a timely manner and understand that failure to do so could result in delayed processing or eligibility denial.
8. **I understand that MSAA will not be responsible for any expenses incurred that occur prior to obtaining the expressed written consent of the MSAA MRI Access Fund.**

Client Signature: _____

Date: _____

Guardian Signature: _____

Date: _____

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Step 4: PHYSICIAN REVIEW FORM

TO BE COMPLETED BY THE PRIMARY CARE PHYSICIAN, NEUROLOGIST, OR FAMILY PRACTITIONER AND RETURNED TO THE PATIENT (CLIENT) FOR SUBMISSION TO THE MULTIPLE SCLEROSIS ASSOCIATION OF AMERICA.

How to help your patient receive an MRI through the **MRI Access Fund**:

- | | |
|---------------|---|
| Step 1 | Please complete the Physician Review Form and sign where indicated |
| Step 2 | Please write a Prescription for a Cranial MRI <u>only</u> for your patient |
| Step 3 | Please return the Review Form and the Prescription to your Patient |

Date: _____

Patient's Name: _____

Physician's Name: _____

Office Address: _____

City _____ State _____ Zip: _____

Office Phone: _____ Email: _____

Please continue on next page

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Step 4: PHYSICIAN REVIEW FORM continued

1. Based on your examination and/or review of medical records, the above-mentioned patient

☐ Exhibits symptom(s) that may indicate a diagnosis of multiple sclerosis

...Or

☐ Has been diagnosed as having multiple sclerosis

2. Do you feel this person warrants a **cranial MRI exam with and without contrast** to either help confirm a diagnosis MS or evaluate current MS disease progression?

☐ Yes

☐ No

3. Are you aware of any other means by which the patient could obtain an MRI if funding were not available through MSAA?

☐ Yes

☐ No

☐ Does not apply

If Yes, please explain: _____

Please include a prescription for a cranial MRI for your patient.

I hereby certify that the statements that I have made are accurate to the best of my knowledge, and I have received the above-mentioned patient's permission to release such statements regarding his or her treatment and/or diagnosis.

Physician Signature: _____ Date: _____

Step 5: RETURN APPLICATION TO MSAA

Return the MRI Access Fund Application and Prescription for an MRI by mail to MSAA, 706 Haddonfield Road, Cherry Hill, NJ 08002 or via fax at 856-488-8257. If you have questions, please call (800) 532-7667, ext. 120.

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