MRI Access Fund Application

375 Kings Highway North, Cherry Hill, NJ 08034
(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-insurance, the MRI Access Fund will assist in covering the remaining co-insurance balance of the MRI cost, up to a specified maximum amount.

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)**
- **Provide required medical insurance documentation**
- **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

Part A. **List below your ADJUSTED GROSS INCOME from your most recent Federal tax return. Please also list the number of people living in your household.**

Adjusted Gross Income: $_______________ Total # of people living in my household: _______

Part B. **Check the Chart.** Based on the information listed above, check the chart below to see if you qualify. If so, continue to Part C. **Example:** Mary Smith has MS and lives with her husband and daughter. There are 3 people in the household. Mary and her husband's Adjusted Gross Income is $52,000. This is less than $61,480 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	$36,180
2	$48,720
3	$61,480
4	$73,800
5	$86,340
6	$98,880
7	$111,420
8	$123,960

Part C. **Document Your Income:** **If qualified, please include a copy of ONE of these documents:**

- your last Federal tax return (Page 1 only of Forms1040, 1040A or 1040 EZ – no attachments, W-2 forms or pay stubs needed)

- an eligibility letter from the US Dept. of Health and Human Services for Temporary Assistance for Needy Families (TANF) or General Assistance (GA); or an eligibility letter for SSI/SSDI from the US Social Security Administration

You can blacken out your SS# on these forms. MSAA maintains strict confidentiality and security of all information provided.

Part D. **Print and sign your name:**
I (the applicant) hereby certify that the information provided to MSAA is accurate to the best of my knowledge. I understand that MSAA has the right to deny this application if the required information and signature are not provided or the income exceeds our limits.

Name: ________________________________ Signature: ____________________________________

Guardian: _____________________________ Signature: ____________________________________

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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
☐ Asian
☐ Black or African American
☐ Chicano or Mexican American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander
☐ White or European
☐ Other (please specify) ____________________

How did you learn about MSAA?

☐ Neurologist
☐ Primary Care Physician
☐ Other Healthcare Providers
☐ Social Services Professionals
☐ Other MS Organizations
☐ Pharmaceutical Company
☐ Internet
☐ Family/Friend
☐ MSAA Client
☐ MSAA Activity
☐ MSAA Publication
☐ MSAA Motivator magazine
☐ Media
☐ Do not recall

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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

☐ Fatigue	☐ Memory loss	☐ Depression	☐ Headaches
☐ Tingling		☐ Balance Difficulty	☐ Speech
☐ Numbness	☐ Difficulty with Problem Solving	☐ Coordination Loss	☐ Swallowing
☐ Burning Sensation		☐ Leg Heaviness	☐ Heat Sensitivity
☐ Pain	☐ Bladder issues	☐ Weakness	☐ Cold Sensitivity
☐ Muscle Spasms	☐ Bowel issues	☐ Tremors	☐ Other Symptoms
☐ Muscle Tightness	☐ Vision Loss/Blur	☐ 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

MS drugs you use:

☐ Aubagio®	☐ Copaxone®	☐ Glatopa™	☐ Ocrevus™	☐ Tecfidera™
☐ Avonex®	☐ Extavia®	☐ Lemtrada®	☐ Plegridy®	☐ Tysabri®
☐ Betaseron®	☐ Gilenya®	☐ Novantrone®	☐ Rebif®	☐ Zinbryta®

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 ☐ 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 #:** ______________________________

Provide insurance documents to show your deductible, deductible balance and coinsurance

Do you have a deductible? (your out-of-pocket health costs, before insurance will pay for expenses)

☐ Yes ☐ No If yes, please list your: **Full Deductible Amount:** $_____________

Please list your current deductible balance: $ ______________________

What is your co-insurance requirement? (a percentage of the cost after meeting your deductible)

☐ 100% ☐ 90%/10% ☐ 80%/20% ☐ 70%/30% ☐ Other: _________

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: ______________

Please make a copy for your records **Fax: 1-856-488-8257** **Revised: 4/17**

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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 only** 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: ____________________________________

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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: ____

4. Do you or a close family member have a financial or compensation arrangement with, or ownership interest in, an imaging center or hospital with an MRI machine?

☐ Yes ☐ No

If Yes, please provide the name of the facility, and its address: ______________________

____

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 with prescription and documented income and insurance to MSAA, 375 Kings Highway North, Cherry Hill, NJ 08034 or via fax at 856-488-8257.

The MRI Access Fund is made possible with support from Sanofi Genzyme, Teva Neuroscience, and Biogen.