MRI Access Fund Application

375 Kings Highway North, Cherry Hill, NJ 08034
(800) 532-7667, ext. 120
www.mymsaa.org; Email: mri@mymsaa.org

What is the MSAA MRI Access Fund?

The MSAA MRI Access Fund assists with the payment of cranial (brain) and cervical (c-spine) magnetic resonance imaging (MRI) scans for qualified individuals who have no medical insurance or cannot afford their insurance costs and require the exam to help determine a diagnosis of multiple sclerosis or evaluate current MS disease progression.

What is offered under the program?

For qualified individuals who have MS or suspected of an MS diagnosis, MSAA will provide financial assistance with:

A. New MRIs: For people in need of **new cranial and/or c-spine MRIs**, MSAA will:

- Refer you to an imaging center that is under contract with MSAA. This applies to people who have **no insurance** or **cannot afford their insurance costs**. MSAA will cover the cost of a cranial (brain) MRI, c-spine MRI, or both; and will pay the imaging center directly.

  OR

- Cover the cost of your medical insurance co-pay or co-insurance balance **up to a maximum of $600 per MRI (cranial and/or c-spine).** MSAA will pay the billing facility directly. You will be responsible for costs exceeding $600 per MRI.

B. Payment For Past MRIs: For people who have had a **cranial and/or c-spine MRI with a date of service from July 1, 2020 to present**, MSAA will pay the remaining costs **up to a maximum of $600 per MRI.** MSAA will pay the billing facility directly. We do not reimburse individuals. You will be responsible for costs exceeding $600 per MRI. This is to be used as a one-time option. Individuals should seek New MRI assistance when reapplying to MSAA.

To qualify for the MRI Access Fund, you must:

- **Meet Income Eligibility or Indicate a Financial Need due to the COVID-19 pandemic**
- **Have a confirmed MS diagnosis or seeking an MS diagnosis**
- **Have not received MSAA MRI assistance within the past 24 months**
- **Complete the application in full, sign and return all required information to MSAA**
- **Avoid scheduling any new MRI appointments until directed by MSAA**
- **Return to MSAA via: Fax (856) 488-8257; Mail: 375 Kings Highway North, Cherry Hill, NJ 08034; Email: MRI@mymsaa.org.**

The MSAA MRI Access Fund is made possible with support from Biogen, EMD Serono, Genentech, and Sanofi Genzyme.

Step 1: INCOME ELIGIBILITY and FINANCIAL NEED

IMPORTANT UPDATE:
Under standard program guidelines, MSAA requests applicants to list their yearly family income based on their most recently filed income tax form. The listed income is compared to the chart below, which triples the federal poverty guidelines, to determine financial eligibility. However, MSAA recognizes your current financial situation may have been negatively affected by the recent COVID-19 pandemic. As a result, we are currently accepting two options for income eligibility:

Option 1. Sudden Financial Need

Option 2. Standard Income Eligibility

Option 1. If your financial situation has been negatively affected by the COVID-19 pandemic and you are currently facing economic hardship, please complete and sign below.

☐ I (the applicant) hereby certify that I am experiencing sudden financial hardship as a result of the COVID-19 pandemic and require MSAA's assistance for the MRI Access Fund.

Please explain how your financial situation has changed: _____

_____ Signature: _____ Date: _____

Option 2. If your financial situation has not been affected by the COVID-19 pandemic, please list your family income and the number of people living in your household. Please check the chart below to see if your income falls below the listed level. If it does, please sign below.

My Yearly Family Income is: $_____. The number of people in my household is: ____.

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

Persons living in the Household	Income
1	$38,500
2	$52,000
3	$65,000
4	$79,000
5	$92,000
6	$105,500
7	$119,000
8	$132,500

By my signature below, I (the applicant) hereby certify the information provided to MSAA is true and accurate and my yearly family income falls below the level listed in the chart per persons living in the household.

Signature: _____ Date: _____

Step 2: INTAKE FORM

Name: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Personal Connection to MS: ☐ Individual with MS ☐ Not diagnosed but suspected ☐ Diagnosed w/CIS

Date of Birth: _____ **Marital Status:** _____ **Gender:** _____

Race: (please check all that apply)

☐ American Indian or Alaska Native ☐ Asian or Pacific Islander ☐ Black or African American

☐ Hispanic or Latino ☐ White or Caucasian ☐ Other: _____

Primary Language: (please select one)

☐ English ☐ Spanish ☐ Other: _____

Referred to MSAA via: (please select one)

☐ Family/Friend ☐ Healthcare Professional ☐ Internet Search

☐ Media (newspaper, etc.) ☐ MSAA Email ☐ MSAA Event

☐ MSAA Event Mailing ☐ MSAA Publication ☐ MSAA Website

☐ Other ☐ Other MS Organization ☐ Social Media

☐ Solicitation ☐ Swim for MS Brochure ☐ Swim for MS Partner

☐ Volunteer Match ☐ Unknown

MS Classification: (please select one)

☐ Primary Progressive MS ☐ Progressive Relapsing MS ☐ Relapsing Remitting MS

☐ Secondary Progressive MS ☐ Unclear

Year Diagnosed: _____

Symptoms: (please check all that apply)

__ Balance Difficulty
__ Bladder Problems
__ Bowel Problems
__ Burning Sensation
__ Cold Sensitivity
__ Coordination Loss
__ Depression
__ Difficulty Problem Solving
__ Dizziness/Vertigo
__ Fatigue
__ General Weakness
__ Headaches
__ Heat Sensitivity
__ Leg Heaviness
__ Loss of Memory/Attention
__ Muscle Spasms
__ Muscle Tightness
__ Numbness
__ Other Symptoms
__ Pain
__ Speech Difficulty
__ Swallowing Difficulty
__ Tingling
__ Tremors
__ Vision Loss/Blur
__ Vision Pain
__ N/A

Mobility Issues/Using: (please check all that apply)

☐ None ☐ Occasional ☐ Moderate ☐ Always

☐ Cane ☐ Crutches ☐ Walker ☐ Scooter ☐ Wheelchair

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

If yes, please select your **current** treatment drug:

__ Aubagio®
__ Avonex®
__ Bafiertam™
__ Betaseron®
__ Copaxone
__ Extavia®
__ Gilenya®
__ Glatiramer acetate
__ Glatopa®
__ Lemtrada®
__ Mavenclad®
__ Mayzent®
__ Novantrone®
__ Ocrevus™
__ Plegridy®
__ Rebif®
__ Tecfidera®
__ Tysabri®
__ Vumerity™
__ Zeposia®

Tests You've Had: (select all that apply) ☐ Evoked potentials ☐ MRI (brain) ☐ MRI (spine) ☐ Spinal tap

Primary care partner: _____

Care partner can speak on behalf of client? ☐ Yes ☐ No

Step 3: MRI REQUEST – Sign and Complete Below

☐ **Yes, I certify the information I provide to MSAA is accurate to the best of my knowledge. I understand MSAA can contact me, my doctor or insurance carrier to process my application.**

Signature: _____ **Date:** _____

PLEASE SELECT ONE (1) OPTION ONLY:

☐ **Option A – I need a NEW cranial (brain) MRI, or NEW c-spine MRI, or both**

☐ **Option B – I need my bill for PAST cranial and/or c-spine MRIs paid for by MSAA**

Based on your selection, please complete the matching section below.

A. New MRI Request: For people seeking new cranial (brain) and/or c-spine MRIs, please check the appropriate boxes below, provide the requested information below.

Please check **ONE (1)** response below to describe your health insurance status:

Currently I: ☐ Lack health insurance ☐ Have coverage but cannot afford my insurance costs

Insurance information (if unsure, please ask your doctor's office or insurance company)

- Name of insurance carrier (including Medicare): _____
- Policy deductible: $ _____ Current deductible balance: $_____
- Co-insurance: ☐ 90%/10% ☐ 80%/20% ☐ 70%/30% ☐ N/A ☐ Copay: $ _____

Based on my doctor's recommendation, I am in need of a:

☐ Cranial (brain) MRI ☐ C-Spine MRI ☐ Both Cranial & C-Spine MRIs

☐ I might require an open MRI machine due to concerns with claustrophobia, weight, etc.

B. Payment For Past MRIs – from July 1, 2020 to present

For people seeking payment assistance for cranial (brain) and/or c-spine MRIs with a date of service **from July 1, 2020 to present**, please provide the requested information below.

Please check **ONE (1)** response below to describe your health insurance status:

Currently I: ☐ Lack health insurance ☐ Have coverage but cannot afford my insurance costs

My balance due on my cranial (brain) MRI is $ _____ and/or my balance due on my c-spine MRI is $ _____. If approved, **MSAA payment will not exceed $600 per MRI.** MSAA will pay the facility. **PLEASE INCLUDE A COPY OF YOUR INVOICE FOR PAYMENT.**
Important Note: This is to be used as a one-time option. Individuals should seek New MRI assistance when reapplying to the MSAA MRI Access Fund.

Step 4: 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. I have or I am seeking a medically confirmed diagnosis of multiple sclerosis by a licensed healthcare professional.

2. If MSAA needs to verify the information that I have provided, then I will grant permission in writing to MSAA to review my physician, insurance, and tax records.

3. 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.

4. I understand that any payment will be made directly to the imaging center.

5. 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.

6. 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.

7. 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.

8. 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.

9. **I understand that I must meet program eligibility criteria and comply with stated instructions in order to receive service through MSAA's MRI Access Fund.**

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Step 5: PHYSICIAN REVIEW FORM and MRI ORDER*

***Step 5 is only needed if you are applying for a NEW MRI (Option A).**

If you need payment for PAST MRIs, skip Step 5 and submit your application.

For people needing a NEW brain or c-spine MRI, MSAA:

- **NEEDS the MRI order/prescription from your doctor. This is a requirement. Please obtain the MRI order from your doctor and include it with this application. Also, your doctor's office can fax it to MSAA at (856) 488-8257.**

- **WOULD LIKE your doctor to complete and sign this form below. This is optional since we understand the current challenges affecting your ability to see your doctor and/or their ability to meet new, overwhelming demands.**

Patient Name: _____ Date: _____

Physician Name: _____ Phone: _____

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

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

   OR

   ☐ Has a diagnosis of multiple sclerosis

2. To help either confirm a diagnosis of MS or evaluate current MS disease progression, the above-mentioned patient requires a:

   ☐ Cranial MRI ☐ C-Spine MRI ☐ Both a Cranial and C-Spine MRI

   .

3. I, 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 facility name and address: _____

   _____

   ☐ **Yes, I hereby certify that the above information provided to MSAA is accurate to the best of my knowledge. I have received the above-mentioned patient's permission to release such statements regarding his or her treatment and/or diagnosis.**

   Physician Signature: _____ Date: _____

Please include the MRI prescription/order with this application or have your doctor's office fax it to (856) 488-8257.

Application Reminder Page

Please KEEP THIS PAGE for your records.

Before returning the MRI application, please make sure to:

- Complete Step 1 (Income Eligibility or Financial Need)
- Complete Step 2 (Intake Form)
- Complete Step 3 (MRI Request). **Please select just one (1) option, A OR B**; sign where needed; and **send invoice if selecting Option B.**
- Sign the Terms Agreement Form (Step 4)
- Complete Step 5 and include the MRI order if applying for a new MRI

Important points to remember:

- Please **DO NOT SCHEDULE an MRI appointment** until you have been contacted by MSAA and received official approval.
- Additional costs such as doctor's visits, reading or lab fees are not covered by the program.
- **You must wait 24-months after receiving financial assistance from MSAA for your MRI(s) to reapply to the MRI Access Fund.**
- **Payment for Past MRIs is for a one-time option. Individuals should apply for a New MRI if seeking renewed assistance.**
- The MRI Access Fund is not an emergency-based service. Applications are processed on a first-come, first serve basis. Please allow MSAA a few weeks to process your application. Thank you!

Return to: MSAA, 375 Kings Highway North, Cherry Hill, NJ 08034, or fax to (856) 488-8257.

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