



MULTIPLE SCLEROSIS  
ASSOCIATION OF AMERICA

*Improving Lives Today!*<sup>™</sup>

# ***MRI Access Fund Application***

375 Kings Highway North, Cherry Hill, NJ 08034

(800) 532-7667, ext. 120

Web: [www.mymsaa.org](http://www.mymsaa.org); Email: [mri@mysaa.org](mailto:mri@mysaa.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.

# MSAA MRI Access Fund Application

## 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 \$60,480 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	\$35,640
2	\$48,060
3	\$60,480
4	\$72,900
5	\$85,320
6	\$97,740
7	\$110,190
8	\$122,670

**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 Forms 1040, 1040A or 1040 EZ – no attachments or W-2 forms 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: \_\_\_\_\_

# MSAA MRI Access Fund Application

## 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)

- |   |  |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Hispanic or Latino                        |
| <input type="checkbox"/> Asian                            | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> White or European                         |
| <input type="checkbox"/> Chicano or Mexican American      | <input type="checkbox"/> Other (please specify) _____              |

### How did you learn about MSAA?

- |  |  |
|--|--|
| <input type="checkbox"/> Neurologist                   | <input type="checkbox"/> Family/Friend           |
| <input type="checkbox"/> Primary Care Physician        | <input type="checkbox"/> MSAA Client             |
| <input type="checkbox"/> Other Healthcare Providers    | <input type="checkbox"/> MSAA Activity           |
| <input type="checkbox"/> Social Services Professionals | <input type="checkbox"/> MSAA Publication        |
| <input type="checkbox"/> Other MS Organizations        | <input type="checkbox"/> MSAA Motivator magazine |
| <input type="checkbox"/> Pharmaceutical Company        | <input type="checkbox"/> Media                   |
| <input type="checkbox"/> Internet                      | <input type="checkbox"/> Do not recall           |

*Please continue on next page*

# MSAA MRI Access Fund Application

## 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®  
 Glatopa®  Lemtrada®  Novantrone®  Plegridy®  Rebif®  Tecfidera®  Tysabri®

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

If yes, please list location: \_\_\_\_\_

*Please continue on next page*

# MSAA MRI Access Fund Application

## 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](http://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:** \$ \_\_\_\_\_

Is your current deductible balance more than \$500?

- Yes       No      If yes, 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 \_\_\_\_\_

# *MSAA MRI Access Fund Application*

## **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: \_\_\_\_\_

# *MSAA MRI Access Fund Application*

## **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**:

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

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Office Address: \_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Email: \_\_\_\_\_

***Please continue on next page***

# MSAA MRI Access Fund Application

## 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.