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 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.

  Important Note: For new MRIs through MSAA – Please DO NOT SCHEDULE an MRI appointment until you have been contacted by MSAA and received official approval.

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, 2018 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.

Important Note: Clients seeking Payment For Past MRIs from MSAA must apply to the MRI Access Fund, provide all required documents and meet income eligibility requirements.

All applicants must complete the required steps and **submit the necessary documentation** – **INCLUDING PROOF OF INCOME** for application review. **Return the MRI Access Fund application to: MSAA, 375 Kings Highway North, Cherry Hill, NJ 08034, or fax to: 856-488-8257.**

How do I qualify?

To qualify for the MRI Access Fund you must:

- Have a confirmed diagnosis of multiple sclerosis or the suspicion of having multiple sclerosis by a qualified healthcare professional
- Not have received MSAA financial assistance for your MRI(s) within the past 24 months
- Complete the application in full and return all required information to MSAA. Incomplete applications will be held until all information, documents and signatures are provided
- Comply with program requirements such as scheduling an MRI appointment when directed, going to the MSAA-referred imaging center, submitting bills in a timely manner, etc.
- Meet income eligibility guidelines & **SEND PROOF OF INCOME**.

Step 1: INCOME ELIGIBILITY

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: _____

To help expand our level of service, MSAA **triples** the Federal Poverty Guideline for income eligibility. Please see chart below, which is adjusted by 300%, as our guide in determining income eligibility.

Persons living in the Household	Income **(Not to exceed)**
1	$37,470
2	$50,730
3	$63,990
4	$77,250
5	$90,510
6	$103,770
7	$117,030
8	$130,290

If your income is at or below what is listed in the chart for your family size (i.e., a family of 3 earning $63,990 or less would qualify), then please submit proof of income as noted below.

YOU MUST SUMBIT PROOF OF INCOME AS NOTED BELOW!

a. **Copy of your last Federal tax return (Forms1040, 1040A or 1040 EZ – no attachments, W-2 forms or pay stubs needed)**

b. **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.

Step 2: INTAKE FORM

Name: _____

Address: _____

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

Home Phone: _____ Cell Phone: _____

Email: _____ Date of Birth: _____Gender: _____

Marital Status: _____ Primary care partner: _____

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/learned about MSAA via (please select all that apply):

__ Family/Friend
__ Media
__ MSAA Event Mailing
__ Other MS Organization
__ Swim for MS Brochure
__ Healthcare Professional
__ MSAA Email
__ MSAA Publication
__ Social Media
__ Swim for MS Partner
__ Internet Search
__ MSAA Event
__ MSAA Website
__ Solicitation
__ Volunteer Match

MS Classification (please select one):

__ Primary Progressive MS
__ Progressive Relapsing MS
__ Relapsing Remitting MS
__ Secondary Progressive MS
__ Unclear

Year Diagnosed: _____ Mobility Issues:__ Always __ Moderate __ Occasional __ None

Symptoms (please list all that apply):

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

Are you currently taking a disease-modifying therapy (DMT) for MS? [ ] Yes [ ] No
If yes, please select your **current** treatment drug:

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

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

Step 3: MRI REQUEST – Please select options A *(OR)* B

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, and sign.

☐ I lack medical insurance and cannot afford the cost of a cranial MRI, c-spine MRI, or both

☐ I have medical insurance (private or Medicare), but I cannot afford my deductible balance, and/or co-pay or co-insurance cost for a cranial MRI, c-spine MRI, or both.

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

☐ **Yes, I hereby certify that the above information provided to MSAA is accurate to the best of my knowledge. I understand MSAA has the right to request additional information from me, my doctor or insurance carrier to help process my application.**

Signature: _____ **Date:** _____

B. Payment For Past MRIs* (Pick A or B but not both)

*Only for MRIs with a Date of Service of July 1, 2018 to present

For people seeking payment assistance for a past cranial (brain) MRI, c-spine MRI, or both, with a date of service **from July 1, 2018 to present**, please check the appropriate boxes below, provide the requested information, and sign.

☐ I lack medical insurance and cannot afford to pay the balance due on my cranial MRI, c-spine MRI, or both, for my MS diagnosis or follow-up care.

☐ I have medical insurance (private or Medicare), but cannot afford to pay the co-insurance or copay balance on my cranial MRI, c-spine MRI, or both, for my MS diagnosis or follow-up care.

Please list your balance due $ _____ and **include a copy of the invoice.** If approved, **MSAA payment will not exceed $600 per MRI.** MSAA will pay the facility.

☐ **Yes, I hereby certify that the above information provided to MSAA is accurate to the best of my knowledge. I understand MSAA has the right to request additional information from me, my doctor or insurance carrier to help process my application.**

Signature: _____ **Date:** _____

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. 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.

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 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: _____

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

Step 5: PHYSICIAN REVIEW FORM*

***Only needed if you are applying for Option A: New MRI. If you are applying for payment of past MRIs, please skip this form and submit your application to MSAA.**

The following information must be completed and signed by the applicant's neurologist or other healthcare provider. The physician **must also include an MRI prescription** for the applicant.

Name of Patient (applicant): _____ Date: _____

Physician's Name: _____

Office phone: _____ Fax: _____

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 it can be faxed along with this page to MSAA, Attn: MRI Dept., at 856-488-8257.**

MRI Access Fund Application Reminder Page

Please KEEP THIS PAGE for your records.

Before returning the MRI application, please make sure to:

- **INCLUDE DOCUMENTED PROOF OF INCOME!!!**
- 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 seeking reimbursement.
- Sign the Terms Agreement Form (Step 4)
- Have your doctor complete and sign the Physician Review Form (Step 5), if applying for a new MRI, **and include the prescription**

Other Important Notes:

- 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.**
- 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!

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