MRI Access Program Application

375 Kings Highway North
Suite B
Cherry Hill, NJ 08034
(800) 532-7667
Email: mri@mymsaa.org

Please allow 45 days for a decision on your application

All personal and medical information voluntarily provided to MSAA during the application process may be used or shared for the sole purpose of acquiring an MRI. MSAA's policy is to strictly maintain the confidentiality and security of all personal information.

To qualify for the MRI Access Program:

- ✓ Meet the Income Eligibility Requirement.
- ✓ Have a confirmed MS diagnosis or seeking an MS diagnosis.
- ✓ Have not received MSAA MRI assistance within the past 24 months.
- ✓ Please avoid scheduling any new MRI appointments until a determination on your application has been made by MSAA.
- ✓ Return application with signature and required information to MSAA via: Email: MRI@mymsaa.org; Fax: (856) 488-8257; or Mail: 375 Kings Highway North, Suite B, Cherry Hill, NJ 08034.

MSAA will provide qualified individuals who have MS or are suspected of having an MS diagnosis financial assistance with either **New MRI(s)** or **Payment for Past MRI(s)**.

New MRI(s) - MSAA will cover the cost for a new MRI up to a **maximum of $750 per MRI (cranial and/or c-spine)**. MSAA will pay the imaging center directly. You will be responsible for costs exceeding $750 per MRI. For individuals who believe their high deductible will leave a balance, even after MSAA provides $750 payment, MSAA will refer you to a contracted imaging center.

Payment for Past MRI(s) - MSAA will cover up to $500 per MRI for a **cranial and/or c-spine MRI with a date of service within the past six months of the date of your application.** MSAA will pay the imaging center directly. MSAA does not reimburse individuals. You will be responsible for costs exceeding $500 per MRI.

INCOME ELIGIBILITY REQUIREMENT

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. MSAA utilizes Experian Health to verify income levels as part of the overall eligibility evaluation process. If you are income qualified, please visit our website to learn more about our Cooling Program and Equipment Distribution Program at www.mymsaa.org.

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	$39,000
2	$52,500
3	$66,000
4	$79,500
5	$93,500
6	$107,000
7	$120,500
8	$134,000

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 my household. I (the applicant) understand that I am providing 'written instructions' to MSAA under the Fair Credit Reporting Act authorizing MSAA to obtain information from my credit profile or other information from Experian Health. I authorize MSAA to obtain such information solely to verify income eligibility for MSAA's MRI Access Program.

Signature:_____Date: _____

INTAKE FORM

Name:_____

Address:_____

City:_____State: _____ Zip: _____

Home Phone:_____ Cell Phone: _____

Email: _____

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
- ☐ Prefer not to answer
- ☐ Other: _____

Primary Language: (please select one)

- ☐ English
- ☐ Spanish
- ☐ Other: _____

Referred to MSAA via: (please select one)

- ☐ Healthcare Professional
- ☐ Other
- ☐ MSAA Event
- ☐ Internet Search
- ☐ Media (newspaper, etc.)
- ☐ Solicitation
- ☐ Other MS Organization
- ☐ MSAA Publication
- ☐ Volunteer Match
- ☐ Family/Friend
- ☐ MSAA Email
- ☐ MSAA Website
- Social Media
- ☐ Unknown
- ☐ MSAA Event Mailing

MS Classification: (please select one)

- ☐ Primary Progressive
- ☐ Progressive Relapsing
- ☐ Relapsing Remitting
- ☐ Secondary Progressive
- ☐ Diagnosed w/RIS
- ☐ Diagnosed w/CIS
- ☐ Unclear/Unknown

Year Diagnosed (please mark N/A if applying for a diagnostic MRI): _____

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

- ☐ None
- ☐ Occasional
- ☐ Moderate
- ☐ Always
- ☐ Cane
- ☐ Crutches
- ☐ Walker
- ☐ Scooter
- ☐ Wheelchair

Symptoms: (please check all that apply)

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

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®	□ Kesimpta®
□ Lemtrada®	□ Mavenclad®	□ Mayzent®	□ Novantrone®	□ Ocrevus™
□ Plegridy®	□ Ponvory ™	□ Rebif®	□ Tecfidera®	□ Tysabri®
□ Vumerity™	□ Zeposia®			

Tests You've Had: (select all that apply)

□ Evoked potentials □ MRI (brain) □ MRI (spine) □ Spinal tap

Care partner can speak on behalf of client in communications with MSAA? □ Yes □ No

Care Partner Name: _____

MRI REQUEST

PLEASE SELECT ONE (1) OPTION ONLY:

□ **New MRI(s) Request- valid for six (6) months from the date of your application**

Please check if the following applies:

□ I am in need of open MRI machine due to concerns with claustrophobia, weight, etc.

□ **Payment for Past MRI(s) – within the past six (6) months of the date of your application**

For people seeking payment assistance for cranial (brain) and/or c-spine MRI(s) with a date of service within the past six months of the date of your application, please provide a copy of your bill. Please make sure the bill includes:

- A description of the MRI(s)
- Where to make checks payable to
- Imaging center/billing facility contact information.

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

3. 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 Program and this terms agreement.

4. I release and hold harmless the **Multiple Sclerosis Association of America, Inc**., and the supporters of the MRI Access Program and their respective officers, employees, agents, funders and members for any resulting adverse effects of the test and/or resulting treatment.

5. 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.

6. I agree to comply with MSAA requests for follow-up correspondence and submission of necessary billing information and/or income verification information in a timely manner and understand that failure to do so could result in delayed processing or eligibility denial.

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

Client Signature:_____ Date: _____

Please allow 45 days for a decision on your application

PHYSICIAN REVIEW FORM

Please complete only if you are the Physician requesting **New MRI(s)** for the applicant. You do not need to complete this step if the applicant is requesting payment for **Past MRI(s)**.

Physician Name:_____ Physician Phone: _____

Physician Address: _____

Physician Email:_____ Patient Name: _____

Patient Date of Birth: _____

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

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: _____

If approved, please coordinate with your doctor to have your MRI script faxed to the imaging center that will perform your MRI(s).

Courtney Blewett, Manager of Mission Delivery MRI Phone: (800) 532-7667 ext. 142; Fax: (856) 488-8257
Email: MRI@mymsaa.org