MRI Institute Application

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Web: www.msassociation.org; Email: mriinstitute@msassociation.org

What is the MSAA MRI Institute?

Supported by a charitable contribution from EMD Serono and Pfizer, the MSAA MRI Institute is a national program to assist individuals with a diagnosis of multiple sclerosis in acquiring a follow-up **Cranial MRI**. Patients and their physicians can use this information to evaluate disease progression and better manage the ever-changing course of MS.

The MSAA MRI Institute will work with eligible individuals, their doctor, imaging centers and insurers to help fund the necessary MRI. Anyone needing an MRI exam specifically to determine a diagnosis of MS is not eligible.

What services are provided through the MRI Institute?

Insurance payment assistance: For those of low/moderate income who have medical insurance (including Medicare) but are unable to meet the co-payment, the MRI Institute will work to cover the remaining balance of the MRI test.

Partial or Full payment: For those of low/moderate income who do not have medical insurance or cannot afford the deductible on their insurance, the MRI Institute will work to pay for the MRI at a negotiated discount rate from contracted imaging centers across the country.

Who is eligible?

Individuals with a confirmed diagnosis of multiple sclerosis who:

- **Complete Steps 1 – 5 of this application and return it to MSAA;**
- **Meet income requirements (Step 1), and receive approval from MSAA prior to having an MRI (no reimbursements provided or payment of bills in collection);**
- **Seek Cranial MRIs only (cervical spine, lumbar and thoracic spine MRIs not covered);**
- **Submit all necessary bills to MSAA in a timely manner;**
- **Have not received an MSAA-funded MRI exam in the previous two years.**

Important Notes:

- The MRI Institute 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

Name: ____________________________ ***Phone:*** (____)_______________ ***Date:*** __________

Address: ____

Part A. YEARLY FAMILY INCOME is defined as all earned wages and other reported income (i.e. disability, pension, alimony, child support, etc.) from last calendar year for the person with MS **and** his or her spouse or partner living in the home.

My Yearly Family Income is: $____________________.

The total number of people living in my household is: _____________.

Part B. Based on the information above, check the chart to see if your income is below the listed amount. If so, proceed to Part C and continue the application.

Example: Mary Smith has MS. She lives with her husband and daughter. Thus, there are 3 people in the household. Mary and her husband's combined Yearly Family Income is $46,000. This is less than $54,930 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	$32,490
2	$43,710
3	$54,930
4	$66,150
5	$77,370
6	$88,590
7	$99,810
8	$111,030

Part C. Please Sign Below:
By my signature below, I (the applicant) hereby certify that the information provided to MSAA is true and accurate to the best of my knowledge. I also understand that MSAA has the right to request written income verification if needed and/or deny this application if the required information and signature are not provided or the income exceeds our limits.

Signature: _____________________________________ Date: _________________________

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Step 2: PERSONAL DATA FORM

You are:

☐ An Individual w/MS ☐ A Care Partner ☐ A Physician ☐ Social Services Professional
☐ Medical Professional ☐ Friend or Relative of someone with MS ☐ Other ______________________

Name ____
Address ____
____
____
City County State Zip

Date of Birth ____________ ☐ **Female** ☐ **Male** **Marital Status** ______________________________

Home Phone______________ Work Phone ______________ Cell Phone ______________
Fax ____________________ Email address ____

The return of this form enables you to apply for all MSAA programs and services and to receive a free, ongoing subscription to the MSAA quarterly magazine, *The Motivator*. If you do not wish to receive *The Motivator*, please check the box below.

☐ I do not wish to receive the MSAA quarterly magazine, *The Motivator*. ☐ I do not wish to receive MSAA emails.

How did you learn about MSAA?

☐ Neurologist
☐ Primary Care Physician
☐ Other HealthCare Providers
☐ Social Services Professional
☐ Other MS organizations
☐ MSAA Client
☐ MSAA Activity
☐ MSAA Publication
☐ Motivator
☐ Friend/Family
☐ Pharmaceutical Company
☐ Internet
☐ Phone Book
☐ Volunteer
☐ Media
☐ Fundraising Call
☐ Fundraising Letter
☐ Do not recall

For assistance in completing this form or for more information on MSAA programs and services, please contact one of our Helpline Consultants at 800-532-7667

Important Note:

MSAA's policy is to strictly maintain the confidentiality and security of all personal and medical information. MSAA will use the personal and medical information, which has been voluntarily provided, only to assist in acquiring requested services or benefits. MSAA will not share names or other individually identifiable health information unless it is necessary to acquire a requested service or benefit.

Please continue on next page

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Step 2: PERSONAL DATA FORM continued

For individuals with MS, 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 *(check all that trouble you)*

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

Tests you've had: ☐ MRI Brain ☐ MRI Cervical Spine ☐ MRI Lumbar Spine ☐ MRI Thoracic Spine ☐ Spinal Tap ☐ Evoked Potentials

MS drugs you use: ☐ Avonex ® ☐ BetaSeron ® ☐ Copaxone ® ☐ Novantrone ® ☐ Rebif ® ☐ Tysabri ®

☐ Other: ____

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

If yes, please list location: ____

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):

____

Annual Income *(for family living in primary domicile)*

☐ Less than $10,000
☐ $10,001 to $20,000
☐ $20,001 to $30,000
☐ $30,001 to $40,000
☐ $40,001 to $50,000
☐ $50,001 to $60,000
☐ $60,001 to $70,000
☐ $70,001 to $80,000
☐ $80,001 to $90,000
☐ $90,001 to $100,000
☐ More than $100,000

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Step 2: PERSONAL DATA FORM continued

Name: ____ **Date of Birth**: ________________________

At present, I am …

☐ Receiving private and/or Medicare health insurance coverage (private includes yourself as primary or secondary)**

☐ Without health insurance coverage*

☐ Waiting to receive private and/or Medicare health insurance coverage

*For those who do not have health insurance or are waiting, please proceed to the next page.

**For those with private and/or Medicare health insurance, please complete the information below.

Insurance Provider: ______________________________ ID card #: __________________________

Address: ____

Phone ( ) ___________________________ Fax ( ) ___________________________

Do you have a deductible? ☐ Yes ☐ No

Insurance Deductible Amount: $________________

Balance of Deductible Not Met: $________________

What is your insurance co-payment? (i.e., will insurance cover 100% of this MRI exam?)

☐ 100% ☐ 80% - 20% ☐ 70% - 30% ☐ Other: _________________________

Do you need insurance pre-approval for your MRI exam? ☐ Yes ☐ No

Has your insurance denied your MRI exam? ☐ Yes ☐ No (If yes, why ____________)

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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, and (if requested) 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 Institute.

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 Institute and this terms agreement.

5. I release and hold harmless the **Multiple Sclerosis Association of America, Inc**., and the supporters of the MRI Institute, EMD Serono, Inc. and Pfizer Inc. and their respective officers, employees, agents, funders and members for any resulting adverse affects 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 Institute.**

Client Signature: ____ Date: ______________

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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 Institute:

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: ______________________________ Pager: _______________________________

Please continue on next page

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Step 4: PHYSICIAN REVIEW FORM continued

1. Based on your examination and/or review of medical records of the above-mentioned patient, has the person been diagnosed as having multiple sclerosis?

☐ **Yes** ☐ **No**

2. Do you feel this person warrants a **cranial MRI exam with and without contrast** to evaluate the 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: ____

____

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

Use the enclosed return envelope to send MSAA the MRI Institute Application, Income Eligibility Form, the MSAA Personal Data Form, the MRI Institute's Physician Review Form and Prescription for an MRI. If you have questions, please call 1-800-532-7667, ext. 120. Fax # 1-856-488-8257.