



National Headquarters
MRI Diagnostic Fund
706 Haddonfield Road
Cherry Hill, NJ 08002

Tel: 1-800-532-7667

Web-site

www.msassociation.org

Fax: 1-856-488-8257

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MSAA MRI DIAGNOSTIC FUND

What is the MSAA MRI Diagnostic Fund?

The MSAA MRI Diagnostic Fund will pay or assist in paying for an initial magnetic resonance imaging (MRI) exam of the head for clients who have no or inadequate financial means to pay for the test and whose physician may suspect a diagnosis of multiple sclerosis.

MSAA will not pay for additional fees such as lab fees and physician fees for reading the MRI. Anyone who has already had an MRI exam specifically to determine the diagnosis of MS is not eligible. Those Individuals should apply to the *MSAA MRI Institute*.

Who is eligible?

- People with no insurance coverage or have been denied coverage for the MRI exam
- People who do not have financial resources to pay for this test
(Household income must not exceed 3 times the poverty level for your family size)
- People with a written physician referral requesting an MRI exam.

Important Notes:

- **MSAA only funds Cranial MRI's for the purpose of initial diagnosis of MS.**
- **The Income Guidelines only apply to the following MSAA programs: Cooling Distribution, Equipment Distribution, Home Modification,**
- **MRI Institute, MRI Diagnostic, and Therapeutic Services.**
- **MSAA encourages all interested individuals to return the Personal Data Form and become a member. This will enable you to receive *The Motivator* magazine, publications, and other available services.**

MSAA MRI DIAGNOSTIC FUND APPLICATION FORM

Name: _____ Phone: (____) _____ Date: _____

Address: _____ City _____ State _____ Zip _____

INCOME ELIGIBILITY

Part A. YEARLY FAMILY INCOME is defined as all disability/pension income from the person with MS and all earned wages from his/her spouse/partner for the previous calendar year. Income from adult children and/or seniors living in the home is excluded.

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 \$49,800. This is less than \$52,800 listed on the chart, so she qualifies.

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

Persons living in the Household	Income
1	\$31,200
2	\$42,000
3	\$52,800
4	\$63,600
5	\$74,500
6	\$85,200
7	\$96,000
8	\$106,800

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: _____

MSAA MRI DIAGNOSTIC FUND APPLICATION FORM

If you meet the eligibility criteria and wish to apply for an MRI exam, then complete steps 1, 2, 3, , and 4 and return all documents to MSAA.

- Step 1.** Complete the **Personal Data Form** (separate sheet)
- Step 2.** Complete and sign the MRI Diagnostic Fund **Application Form** and the **Income Eligibility Form**
- Step 3.** Read and sign the **Terms Agreement Form**
- Step 4.** Have your doctor complete the MRI Diagnostic Fund **“Physician Review” Form, Prescription for MRI Test** and return it to you
- Step 5.** Please return the **MRI Diagnostic Fund Application, the Terms Agreement, Income Eligibility Form, the Personal Data Form, the MRI Diagnostic Fund “Physician Review” Form, and a Prescription for MRI** to MSAA, 706 Haddonfield Rd, Cherry Hill, NJ 08002

STEP #2.

The MSAA MRI Diagnostic Fund Application Form

Name: _____ Phone: (____) _____ Date: _____

Social Security Number: _____ Patient's Birth Date: _____

Household Annual Income \$ _____ Number of Persons in Household _____

Insurance Provider: _____ Phone: (____) _____

Address: _____

City : _____ State: _____ Zip Code: _____

Name of Insurance Provider's Contact Person: _____

Employer: _____ Phone: (____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

STEP #3.

MSAA MRI Diagnostic Fund 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 access to insurance or other financial means to provide payment for an MRI diagnostic 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 records, imaging center records, and (if requested) insurance records
2. MSAA will pay only for one physician requested MRI test. Payment will be made directly to the imaging center. 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 this Term Agreement.
3. I also certify that, if accepted as a recipient of the MSAA Diagnostic Fund, I will hold the Multiple Sclerosis Association of America, Inc., its officers, employees, agents and members harmless in any resulting adverse affects of the test and/or resulting treatment.
4. 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.
5. **Approval from MSAA Diagnostic Fund is necessary prior to obtaining the MRI**

Client Signature: _____

Date: _____

STEP #4.**MSAA MRI Diagnostic Fund 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.**

What is the MSAA Diagnostic Fund?

Sponsored by the Multiple Sclerosis Association of America, the Diagnostic Fund pays for an initial, cranial MRI test for individuals suspected of MS but lacking the necessary insurance and/or finances to pay for the exam (providing a physician deems an MRI necessary). Anyone who has already had an MRI exam specifically to determine the diagnosis of MS is not eligible. Application does not ensure approval.

How does the program work?

Upon the approval of each applicant and until MRI-dedicated funding has been exhausted, MSAA will provide payment of the MRI directly to the test provider. Summary results of the test will be held in absolute confidence. Diagnosis of MS is not required for payment, however, a final **billing statement must be provided** by the MRI Imaging Center. MSAA will provide funding for the MRI only and will not be held responsible for any additional fees incurred, including neurologist visits and lab fees.

How to ensure that my patient receives an MRI through this program

- Step 1** Please complete the Physician Review Form and **sign where indicated**
- Step 2** Please **write a prescription** for a diagnostic **MRI of Brain** for your patient
- Step 3** Please **return** the **Physicians Review Form** and prescription **to your patient**

Multiple Sclerosis Association of America

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Physicians Review is not considered a Prescription.

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MSAA MRI DIAGNOSTIC FUND - Physician Review Form

Please PRINT or TYPE information

Patient's Name: _____

Physician's Name: _____

Office Address: _____

City _____ State _____ Zip: _____

Office Phone: _____ Pager: _____

MRI Center preferred: _____

Office Address: _____

City: _____ State _____ Zip: _____

MRI Center Phone: _____

Based on your examination and/or review of medical records of the above-mentioned patient, does the person exhibit symptom(s) that may indicate multiple sclerosis?

Yes No

Do you feel this person warrants an MRI exam? Yes No

Are you aware of any other means by which the patient could obtain an MRI if funding were not available through MSAA? Yes No

If Yes, please explain: _____

MSAA ONLY FUNDS Cranial MRI's

What type of MRI do you recommend?

With contrast Without contrast With/Without contrast

Estimated cost of this procedure: \$ _____

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.

Signature of Physician

Date

STEP #5. Use the enclosed return envelope to send MSAA the MRI Diagnostic Application Form, Income Eligibility Form, Terms Agreement, MSAA Personal Data Form, the MRI Diagnostic Physician Review Form, and Prescription for an MRI. Mail To: MSAA 706 HADDONFIELD ROAD CHERRY HILL, NJ 08002 or Fax 856-488-8257 Tel: 800-532-7667 x120 or x114

Prescription Date: _____

STEP #1.

MSAA PERSONAL DATA

MSAA ID Number
Office Use Only

You are:

- An Individual w/MS
- Medical Professional
- A Care Partner
- Friend or Relative of someone with MS
- A Physician
- Social Services Professional
- 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.

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MSAA PERSONAL DATA continued

For individuals with MS, please complete the following:

MS Classification:	Benign Relapsing/Remitting	Secondary Progressive Progressive Relapsing	Primary Progressive Unclear diagnosis	
Year Diagnosed:	_____			
Other Conditions:	_____			
Wheelchair Use:	None	Occasional	Moderate	Always
Assistive Devices:	Cane	Crutches	Walker	Scooter
	Other: _____			

Symptom <i>(check all that trouble you)</i>	Fatigue	Loss of Memory and Attention	Depression	Headaches
	Tingling	Difficulty with Problem Solving	Balance Difficulty	Speech Difficulty
	Numbness	Bladder Problems	Coordination Loss	Swallowing Difficulty
	Burning Sensation	Bowel Problems	Leg Heaviness	Heat Sensitivity
	Pain	Vision Loss/Blur	General Weakness	Cold Sensitivity
	Muscle Spasms		Tremors	Other Symptoms
	Muscle Tightness		Dizziness/Vertigo	

Tests you've had:	MRI [Brain]	MRI [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	Hispanic or Latino
Asian	Native Hawaiian or Other Pacific Islander
Black or African American	White
Chicano or Mexican American	Other (please specify): _____

Annual Income <i>(for family living in primary domicile)</i>	
Less than \$10,000	\$60,001 to \$70,000
\$10,001 to \$20,000	\$70,001 to \$80,000
\$20,001 to \$30,000	\$80,001 to \$90,000
\$30,001 to \$40,000	\$90,001 to \$100,000
\$40,001 to \$50,000	More than \$100,000
\$50,001 to \$60,000	

PLEASE LIST:

Primary Care Physician: _____ Phone: () _____

Address: _____

Neurologist: _____ Phone: () _____

Address: _____