MRI Institute Application
706 Haddonfield Road
Cherry Hill, NJ 08002

Application Steps:

If you meet the eligibility criteria on page 2 of this application and wish to apply for MRI assistance, then complete steps 1, 2, 3, 4, and 5, and return all documents to MSAA in the enclosed envelope.

Step 1. Complete and sign the MSAA **Income Eligibility Form**

Step 2. Complete the Personal Data Form

Step 3. Read and sign the **Terms Agreement Form**

Step 4. Have your doctor complete the MSAA MRI Institute's **Physician Review Form** and return it to you along **with a prescription for the MRI of the Brain and C-Spine**

Step 5. **Please return the MSAA the MRI Institute Application, the Income Eligibility Form, the MSAA Personal Data Form, the MRI Institute's Physician Review Form, and Prescription for an MRI to MSAA, 706 Haddonfield Road, Cherry Hill, NJ 08002.**

Program Policy:

MSAA provides financial assistance for a future MRI after one year has elapsed from previously funded MRI. MSAA MRI Programs **do not cover**:

- MRI of lumbar and thoracic spine
- Reading Fees and/or Doctors' Fees
- MRI's that have been completed three months prior to submission
- MRI bills that have been turned over to a collection agency
- MRI scheduled appointments prior to MSAA approval

All forms and applications must be completed, signed and submitted to MSAA along with a physician's prescription prior to MRI. Incomplete applications will be returned to the client with an accompanying letter for completion. Medicare co-pay and deductible must be submitted within 6 to 8 weeks of receiving a MRI. All bills must be submitted prior to payment by MSAA.

MSAA™
MULTIPLE SCLEROSIS
ASSOCIATION OF AMERICA

MRI Institute Application

Step 1: INCOME ELIGIBILITY FORM

Name: ______________________ ***Phone:*** (____) ______________ ***Date:*** __________

Address: ____

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 $46,000. 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: ____________________

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MRI Institute Application

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

MSAA™ MULTIPLE SCLEROSIS ASSOCIATION OF AMERICA

MRI Institute Application

Step 2: PERSONAL DATA FORM 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: ______________________________

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

Please list your:

Social Security Number: ______________________ **Date of Birth**: ______________________

Primary Care Physician: ____

Address: ____

Phone ( ) ______________________ Fax ( ) ______________________

Neurologist: ____

Address: ____

Phone ( ) ______________________ Fax ( ) ______________________

MS Center: ____

Address: ____

Phone ( ) ______________________ Fax ( ) ______________________

Insurance Provider: ______________________ Contact person: ______________________

Address: ____

Phone ( ) ______________________ Fax ( ) ______________________

Employer: ____

Address: ____

Phone ( ) ______________________ Fax ( ) ______________________

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, 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 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: ____________

MSAA™ MULTIPLE SCLEROSIS ASSOCIATION OF AMERICA

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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 and/or C-Spine MRI** 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

MSAA Multiple Sclerosis Association of America MRI Institute Application

Step 4: PHYSICIAN REVIEW FORM continued

Preferred MRI Center: ____

Address: ____

Phone: _(_______)__________________________ Fax: _(_______)_________________________

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**

Do you feel this person warrants an MRI exam to evaluate the disease progression?

☐ **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** ☐ **Does not apply**

If Yes, please explain: ____

MSAA WLL FUND CRANIAL AND C-SPINE MRI's

What type of MRI do you recommend?

☐ Cranial, with and without contrast ☐ C-Spine, with and without contrast

☐ Or Both with and 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.

Physician Signature: ____ **Date:** ________________

Step 5: RETURN APPLICATION TO MSAA

Please return the 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 to:

MSAA, 706 Haddonfield Road, Cherry Hill, NJ 08002

If you have questions, please call 1-800-532-7667, exts. 120 or 126 / Fax # 1-856-488-8257.