



# MSAA MRI Institute Application

MULTIPLE SCLEROSIS  
ASSOCIATION OF AMERICA

706 Haddonfield Road, Cherry Hill, NJ 08002 800-532-7667

Web: [www.msassociation.org](http://www.msassociation.org); Email: [mriinstitute@msassociation.org](mailto:mriinstitute@msassociation.org)

## 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**
- Step 5.** Use the enclosed return envelope to send 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.

## Program Policy:

Clients are not eligible for financial assistance for a future MRI through the MRI Institute until two years have elapsed between exams. MSAA MRI Programs **do not cover**:

- MRI of the cervical spine, lumbar and thoracic spine
- Reading Fees and/or Doctors' Fees
- MRI bills that have been turned over to a collection agency
- MRI scheduled appointments prior to MSAA approval (no reimbursement)

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.

# 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: \_\_\_\_\_

# 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	_____	<input type="checkbox"/> Female <input type="checkbox"/> 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?

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Neurologist                  | <input type="checkbox"/> MSAA Client      | <input type="checkbox"/> Pharmaceutical Company | <input type="checkbox"/> Fundraising Call   |
| <input type="checkbox"/> Primary Care Physician       | <input type="checkbox"/> MSAA Activity    | <input type="checkbox"/> Internet               | <input type="checkbox"/> Fundraising Letter |
| <input type="checkbox"/> Other HealthCare Providers   | <input type="checkbox"/> MSAA Publication | <input type="checkbox"/> Phone Book             | <input type="checkbox"/> Do not recall      |
| <input type="checkbox"/> Social Services Professional | <input type="checkbox"/> Motivator        | <input type="checkbox"/> Volunteer              |   |
| <input type="checkbox"/> Other MS organizations       | <input type="checkbox"/> Friend/Family    | <input type="checkbox"/> Media                  |   |

**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*

## Step 2: PERSONAL DATA FORM continued

For individuals with MS, please complete the following:

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

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

Tests you've had:	<input type="checkbox"/> MRI Brain	<input type="checkbox"/> MRI Cervical Spine	<input type="checkbox"/> MRI Lumbar Spine	<input type="checkbox"/> MRI Thoracic Spine
	<input type="checkbox"/> Spinal Tap		<input type="checkbox"/> Evoked Potentials	
MS drugs you use:	<input type="checkbox"/> Avonex® <input type="checkbox"/> BetaSeron® <input type="checkbox"/> Copaxone® <input type="checkbox"/> Novantrone® <input type="checkbox"/> Rebif® <input type="checkbox"/> Tysabri®			
	<input type="checkbox"/> Other: _____			
Are you currently involved in a clinical trial?	<input type="checkbox"/> Yes		<input type="checkbox"/> No	
If yes, please list location:	_____			

<b>Ethnic Origin: (optional)</b>	
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> Black or African American	<input type="checkbox"/> White or European
<input type="checkbox"/> Chicano or Mexican American	<input type="checkbox"/> Other (please specify): _____

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

## **Step 2: PERSONAL DATA FORM continued**

**Please list your: Name:** \_\_\_\_\_

**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: \_\_\_\_\_

## **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:

- |               |   |
|---------------|---|
| <b>Step 1</b> | Please complete the <b>Physician Review Form</b> and sign where indicated               |
| <b>Step 2</b> | Please write a <b>Prescription for a Cranial MRI <u>only</u></b> for your patient       |
| <b>Step 3</b> | Please return the <b>Review Form</b> and the <b>Prescription</b> to your <b>Patient</b> |

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Office Address: \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Pager: \_\_\_\_\_

*Please continue on next page*

## **Step 4: PHYSICIAN REVIEW FORM continued**

Preferred MRI Center: \_\_\_\_\_

Address: \_\_\_\_\_

Phone:     (    )     Fax:     (    )    

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 would estimate the cost of this procedure at: \$ \_\_\_\_\_

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 or 114. Fax # 1-856-488-8257.