Myasthenia Gravis Foundation of Illinois, Inc.
275 N. York Street, Ste. 401 ♦ Elmhurst, Illinois 60126-2752 ♦ www.myastheniagravis.org
630.835.0153 ♦ Toll Free: 800.888.6208 ♦ Email: info@myastheniagravis.org ♦ Fax: 630-563-9181

Member Agency Community Health Charities of Illinois

PATIENT ASSISTANCE PROGRAM

If you are a myasthenia gravis patient and are suffering because of the high cost of medical treatment and prescription medication, the Myasthenia Gravis Foundation of Illinois may be able to provide some relief. MGF of Illinois will cover the cost of medical treatment and medication up to $1,000 per year per person, to the extent funds are available.

These costs do not need to be directly related to treatment for myasthenia gravis but may be for any medical treatment or prescription drug cost you have incurred.

Who is Eligible
You qualify if you meet all of these conditions:

- You have myasthenia gravis
- You are a resident of Illinois or Indiana
- You have a financial hardship that makes it difficult for you to pay medical expenses not covered by insurance

*An MGF of Illinois board member who meets these conditions may apply for assistance up to the same $1,000 annual limit. However, the board member must wait until May 1 of a given year to submit an application.

How the Program Works
For hospital, doctor visit, or medical procedure charges, submit bills after all insurance payments are applied. MGF of Illinois will make payment directly to the healthcare provider. Payment will not be made to an individual patient.

For prescription costs that you pay out-of-pocket, collect your pharmacy receipts. Once you have $200 or more in paid receipts, submit them to the Patient Assistance Program and reimbursement (up to plan limits) will be mailed to you.

You may include both medical bills and prescription receipts in the same application. The total amount of medical and prescription bills that will be paid in one year is $1,000 per person. You may reapply in future years if the program is continued.

To the extent possible, we encourage you to bundle your bills. Generally, the minimum amount you can apply for is $200. If you qualify for a reimbursement, it does not guarantee that funding will be available for a second or later request.

To apply, please send the following to the Myasthenia Gravis Foundation of Illinois:

- Your completed Patient Application
- Supporting documentation
- Medical bills and prescription drug receipts
- The Physician Confirmation Form completed by your doctor

We will review your application upon receipt and let you know if any additional information is needed. We will contact you, generally within 10 business days after receiving your completed information, to tell you of the decision regarding your request for assistance. Any payment will be made shortly afterward.

Please note your information will be kept **totally confidential**; access will be limited to the review committee. Feel free to black out social security numbers. If you don't black out identifying data such as social security numbers, this data will be blacked out upon review.

If you have any questions about the application process, call the MGF of Illinois office at 800-888-6208. The decision made by MGF of Illinois regarding each completed application for payment will be final.

Myasthenia Gravis Foundation of Illinois

Patient Assistance Program Date you are applying: _____/______/_____
PATIENT APPLICATION Amount you are requesting: $____________

Please mail your completed application, along with required documentation to: Myasthenia Gravis Foundation of Illinois, 275 N. York Street, Suite 401, Elmhurst IL 60126-2752.

*This application and supporting documents will be kept **totally confidential**.*
Access to your application will be limited to the review committee.
If you don't black out identifying data such as social security numbers,
this data will be blacked out upon review.

STEP 1: Complete this section.
a. Patient Name: ____

b. Address: ____

c. Telephone #: ________________________ Email: ________________________________

d. Date of birth: ____/____/______

e. Name of person completing this application (if different than patient listed above)

____ Telephone #: ________________________

f. Relationship to patient: _______________________ Email: ______________________________

g. Number of family members living in household: ________

h. Check which applies to the patient:
☐ Unemployed. How long?:______________________
☐ Retired.
☐ Employed. Please list all current employers:

Employer 1: ____
Address: ____
Contact Person:______________________________ Telephone:__________________

Employer 2: ____
Address: ____
Contact Person: ______________________________ Telephone: _________________

STEP 2: Report income. What is the patient's household income? This amount should include income for the patient and the patient's spouse. Include parent or guardian income if the patient is a dependent.

Be sure to include household salaries or wages, public assistance benefits, social security benefits, unemployment benefits, workers' compensation, child support, and any other income.

$________________________ Check one: □ Per year □ Per month

STEP 3: Provide <u>copies of your bill(s)</u> for medical treatment or prescription drugs, <u>after all insurance payments have been applied</u>. For prescriptions, send your prescription receipts from the pharmacy (these include pharmacy name/address, patient name, Rx name and number, date filled, and price). Cash register receipts are not acceptable. Treatment and medication do not need to be related to myasthenia gravis.

STEP 4: Provide documentation of <u>income</u>. Please send <u>COPIES, NOT ORIGINALS</u> as we are unable to return documentation. Your documents should show us you are experiencing a financial hardship (for example, due to low income or a loss of income) that makes it difficult to pay your medical bill(s).

A. If you are <u>receiving Medicaid benefits</u>, you only need to send a copy of your most recent Medicaid card.
B. If you are <u>receiving benefits from SNAP</u> (Supplemental Nutrition Assistance Program), you only need to send a copy of your SNAP card.

C. <u>If you do not have a Medicaid or SNAP card</u>, send your <u>most recent income tax return</u> (first two pages of most recent signed 1040). You also could include copies of any of these items:
   - W-2 withholding statements or unemployment check stubs for the past 90 days
   - Pay check stubs for the past 90 days (For patients who are minors, provide paycheck stubs for heads of household)

If you need help deciding what documentation to send, call MGF of Illinois at 1-800-888-6208.

If you feel additional documentation would help explain your situation, please include copies.

STEP 5: Provide explanation. Please describe why patient is unable to pay bills. (Examples might include low wages, difficulty keeping a job, catastrophic situations such as death or disability in family, divorce, outstanding debts, or other reasons.)

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STEP 6: Get your physician's confirmation. Please have your general practitioner or neurologist complete the attached **Physician Confirmation Form** to confirm you have MG. Return this form with your application or the physician's office can send it directly to MGF of Illinois. This form is required once each year.

STEP 7: SIGN

I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE THE MYASTHENIA GRAVIS FOUNDATION OF ILLNOIS TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED.

Signature of Person Making Request:
____ Date: ____/____/____

Printed Name: ____

Myasthenia Gravis Foundation of Illinois

Patient Assistance Program

PHYSICIAN CONFIRMATION FORM - To be completed each year the first time you request payment

If we have recent form on file for you, this may not be necessary. Call 1-800-888-6208 to confirm.

To the Physician: Your patient may be eligible for financial assistance from the Myasthenia Gravis Foundation of Illinois. Please complete this form so that his/her application may be considered. The form can be returned to MGF of Illinois by you or by the patient. Mail to:

Myasthenia Gravis Foundation of Illinois
275 N. York Street, Suite 401
Elmhurst, IL 60126

PATIENT NAME: ____

PATIENT ADDRESS: ____

CITY: ____ STATE: ____________ ZIP Code: __________

I HEREBY CONFIRM THAT (Patient Name) _________________________________IS MY PATIENT AND THAT HE/SHE HAS BEEN DIAGNOSED WITH MYASTHENIA GRAVIS. IT IS MY UNDERSTANDING THAT HE/SHE HAS A FINANCIAL HARDSHIP AND SHOULD BE CONSIDERED FOR THE MYASTHENIA GRAVIS FOUNDATION OF ILLINIOS PATIENT ASSISTANCE PROGRAM. I UNDERSTAND THE MYASTHENIA GRAVIS FOUNDATION OF ILLNOIS MAY CONTACT ME TO VERIFY THIS INFORMATION.

Physician Printed Name: ____ Date: ____/____/____

Physician Signature: ____

Physician Organization: ____

Address Line 1: ____

Address Line 2: ____

City: ____ State: ____________ ZIP Code: __________