CONQUER MG
Conquer Myasthenia Gravis
Serving Illinois, Northwest Indiana, and Southeast Wisconsin

Formerly known as
Myasthenia Gravis Foundation of Illinois
4055 W. Peterson Ave., Suite 105
Chicago, IL 60646
800-888-6208
www.myastheniagravis.org
info@myastheniagravis.org

PATIENT ASSISTANCE PROGRAM

If you are a myasthenia gravis patient and are struggling with high medical costs, Conquer Myasthenia Gravis (Conquer MG) may be able to provide some relief. Conquer MG will cover the cost of medical treatment, durable medical equipment, 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, Indiana, or Wisconsin
- You have a financial hardship making it difficult to pay medical expenses not covered by insurance

*A Conquer MG 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, medical procedure, or durable medical equipment charges, submit bills after all insurance payments are applied. Examples of durable medical equipment are wheelchairs, chair lifts, and oxygen equipment.

- If you've not yet paid your portion of the bill, Conquer MG will pay the healthcare provider for approved charges.
- If you've already paid your healthcare provider, send us health care provider receipts that reflect your payment as well as the amount covered by insurance, and any approved payment will be made to you.

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 medical bills and receipts for prescriptions and durable medical equipment in the same application. The total amount of these 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, and apply for at least $200 at a time. If you qualify for a reimbursement, it does not guarantee that funding will be available for a later request.

To apply, please send the following to Conquer Myasthenia Gravis:

- Your completed Patient Application
- Supporting documentation
- Medical bills, and receipts for prescription drugs and durable medical equipment
- 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. Help us guard your information; please black out any social security numbers or other sensitive identifying information.

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

Conquer Myasthenia Gravis

Patient Assistance Program Date you are applying: _____/_____/_____

PATIENT APPLICATION

Please mail your completed application, along with required documentation to: Conquer Myasthenia Gravis, 4055 W. Peterson Ave, Suite 105, Chicago, IL 60646.

*This application and supporting documents will be kept **totally confidential**.*
Access to your application will be limited to the review committee.
Help us guard your information; be sure to black out identifying data such as social security numbers.

STEP 1: Complete this section.

a. Patient Name: _____

b. Address: _____

c. Telephone #: _____ Email: _____

d. Date of birth: ____/____/_____ e. Amount you are requesting: $_____

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

_____ Telephone #: _____

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 COPIES of your bill(s) for medical treatment, durable medical equipment, and/or prescription drugs, after all insurance payments have been applied. For prescriptions, send copies of prescription receipts from the pharmacy (these include pharmacy name/address, patient name, Rx name and number, date filled, and price). If possible, copy onto 8-1/2"x11" paper. Cash register receipts are not acceptable. Treatment and medication do not need to be related to myasthenia gravis.

STEP 4: Provide documentation of income. Please send COPIES, NOT ORIGINALS 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 bills. **Please black out any social security numbers or other sensitive identifying information.**

A. If you are receiving Medicaid benefits, you only need to send a copy of your most recent Medicaid card/approval letter.
B. If you are receiving benefits from SNAP (Supplemental Nutrition Assistance Program), you only need to send a copy of your SNAP approval letter.
C. If you do not have a Medicaid or SNAP card, send your most recent income tax return (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 month
    - Pay check stubs for the past month (For minors, provide paycheck stubs for heads of household)

If you need help deciding what documentation to send, call Conquer MG at 1-800-888-6208.

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

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.)

_____

_____

_____

_____

_____

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 Conquer MG. This form is required once each year.

STEP 7: SIGN

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

Signature of Person Making Request:

_____ Date: ____/____/____

Printed Name: _____

Conquer Myasthenia Gravis **(Formerly known as the 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 Conquer Myasthenia Gravis. Please complete this form so that his/her application may be considered. The form can be returned to Conquer MG by you or by the patient. Email a scanned copy to info@myastheniagravis.org. Or mail to:

Conquer Myasthenia Gravis
4055 W. Peterson Ave., Suite 105
Chicago, IL 60646

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 CONQUER MYASTHENIA GRAVIS PATIENT ASSISTANCE PROGRAM. I UNDERSTAND CONQUER MYASTHENIA GRAVIS 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: _____