National Multiple Sclerosis Society

National Multiple Sclerosis Society
Service Provider Intake Form for Healthcare Professionals

Thank you for your interest in receiving healthcare referrals from the National MS Society. Please complete and return this form. Some of the information provided, after being reviewed and approved, will be added to our database for referral purposes.

PLEASE NOTE: If extra space is needed, the fields below expand. If completing this form on paper, and you need extra space, please write locations, services, eligibility, insurance information, and healthcare provider information on a piece of paper and submit with this form. If your practice has multiple locations, please submit a form for each office.

GENERAL INFORMATION

Practice/Company Name:		
Primary street address:	**City**:	**State**:
Zip Code:	**Phone number**:	**Fax number**:
Company Website:	**Company Email**:	

ELIGIBILITY

Please list any eligibility requirements for your services (e.g., referral requirements, age limits, income limits, counties, regions, etc.):

Please list all types of insurance accepted: ☐ Medicare ☐ Medicaid ☐ Dual Eligible (Medicare/Medicaid) ☐ Private Insurance ☐ Private Pay ☐ VA Benefits ☐ TRICARE ☐ Other (please describe):

Do you offer a sliding fee scale, indigent care, or financial assistance? ☐ Yes ☐ No

SERVICES YOU, OR YOUR STAFF, PROVIDE DIRECTLY AT YOUR PRACTICE (check all that apply)

Neurologic care MS diagnosis and second opinion ☐ Ongoing MS medical and symptom management ☐	***Seating/wheelchair assessments*** ☐
MS research or clinical trial participation ☐	***Pain management*** ☐
Self-care education Self-catheterization ☐ Injection training ☐ Skin care ☐	***Neuro-ophthalmology*** ☐ ***Ophthalmology*** ☐
Pediatric neurologic care ☐ *(specific focus)*	***Urological services*** ☐
Counseling Individuals ☐ Couples ☐ Group/family ☐ Children ☐	***General medical care*** *(General Practitioner/Internist)* ☐
Social work services ☐ ***Care management*** ☐	***Dentistry*** ☐
Neuropsychological evaluation ☐	***Gynecological and/or obstetric care*** ☐
Rehabilitation services Physical therapy ☐ Occupational therapy ☐ Speech and language therapy ☐ Cognitive therapy ☐	***Complementary and alternative therapies:*** Acupuncture ☐ Biofeedback ☐ Wellness programs ☐ Nutrition counseling ☐ Massage ☐

PRACTICE INFORMATION

What are your hours of operation?

To what extent is your office accessible to persons with disabilities? (check all that apply)
☐ Wheelchair Accessible ☐ Automatic Doors ☐ Entrance Ramp ☐ Accessible Parking ☐ Office on Ground Floor
☐ Elevator Accessible (if above ground floor) ☐ Accessible Restroom ☐ Accessible Exam Table

Do you or other staff members speak a language other than English? ☐ Yes ☐ No
If yes, please list languages:

Approximate number of unique patients (unduplicated) with MS seen annually :

Are home visits or telemedicine offered? ☐ Yes ☐ No If yes, please describe:

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HEALTHCARE PROFESSIONALS WITH SPECIFIC INTEREST IN MS CARE AT YOUR PRACTICE

Please only list providers with MS experience

First and Last Name*					
Specialty* and professional degree(s)					
Licensed to practice in the state where this practice is located?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Approximate continuing education credits related to MS in the past 2 years?	None ☐	None ☐	None ☐	None ☐	None ☐
Any MS specific training, or certifications	Yes ☐ No ☐ Describe:	Yes ☐ No ☐ Describe:	Yes ☐ No ☐ Describe:	Yes ☐ No ☐ Describe:	Yes ☐ No ☐ Describe:
Board Certified or Board Eligible? ***(for physicians)***	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Prescribes FDA approved MS disease modifying medications, when appropriate? ***(for neurologists)***	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Carries malpractice or liability insurance? If yes, please indicate limits.	Yes ☐ No ☐ Limits:	Yes ☐ No ☐ Limits:	Yes ☐ No ☐ Limits:	Yes ☐ No ☐ Limits:	Yes ☐ No ☐ Limits:
Additional contact information *(Optional- this information is only used to send you Society information for healthcare professionals)*	email phone:	email phone:	email phone:	email phone:	email phone:

** Information with an asterisk is shared with the public as part of referrals.*

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If National MS Society staff members have questions about any of the information provided in this form, please list the name and phone number for the person to contact to get clarification:

PRINTED NAME:
PHONE NUMBER/EMAIL:

Please return completed forms by mail, email or fax to:
National MS Society, Greater Northwest Chapter
Attn: Debra
192 Nickerson Street, Suite 100
Seattle, WA 98109
Email: Debra.Maas@nmss.org
Fax: 206-284-4972

Questions? Please call 1-800-344-4867, press option 2, Ext. 40227 or 206-284-4254, Ext. 40227

OFFICE USE ONLY	
Account Number:	Coding: