Scope of Sales Appointment

Confirmation Form

The Centers for Medicare & Medicaid Services requires sales agents to document the scope of a marketing appointment at least 48 hours prior to any sales meeting when possible, to ensure understanding of what will be discussed between the sales agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

To be completed by Beneficiary or Authorized Representative:

Please INITIAL below beside the product type(s) you want the agent to discuss (required):
(refer to last page for product type descriptions)

_________ **Medicare Advantage Plans (Part C) and Cost Plans**
(initial here)

_________ **Stand-alone Medicare Prescription Drug Plans (Part D)**
(initial here)

_________ **Medicare Supplement (Medigap) Products**
(initial here)

Signature (required):	Signature Date (required): (__ __ /__ __ /__ __ __ __) (M M / D D / Y Y Y Y)

If you are the Authorized Representative, please sign above and print below

Representative's Name:	Relationship to Beneficiary:

By signing this form, you agree to a meeting with a Sales Agent to discuss the product type(s) you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, impact your current or future Medicare enrollment status or automatically enroll you in the plan(s) to be discussed.

To be completed by Agent:

Agent Name *(required)*:	Agent Phone *(required)*:
Plan Assigned Agent ID:	Agent NPN:
Beneficiary Name *(required)*:	Beneficiary Contact Info (Phone or Address): *(optional)*

Initial Method of Contact (check one): ☐ Sales Event ☐ Walk-In ☐ Inbound Call
☐ Permission To Call Card ☐ Other (specify) ______________________________

Plan(s) represented during this meeting:

Explanation required if SOA was not documented and signed at least 48 hours prior to the appointment:
☐ Beneficiary requested next day or same day appointment
☐ Beneficiary requested to discuss additional product types
☐ Beneficiary did not have fax or mail to receive and return SOA before the appointment
☐ Other (explain):______________________________

Agent Signature:	Date of Appointment (required): (__ __ /__ __ /__ __ __ __) (M M / D D / Y Y Y Y)
IMPORTANT: Beneficiary Health Insurance Claim Number (HICN) to be completed by Agent only after receipt of enrollment application	Beneficiary HICN:

Stand-alone Medicare Prescription Drug Plans (Part D)
Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.
Medicare Advantage Plans (Part C) and other Medicare plans
Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).
Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.
Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.
Medicare Point of Service (POS) Plan — A type of Medicare Advantage Plan available in a local or regional area which combines the best feature of an HMO with an out-of-network benefit. Like the HMO, members are required to designate an in-network physician to be the primary health care provider. You can use doctors, hospitals, and providers outside of the network for an additional cost.
Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.
Medicare Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.
Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.
Medicare Supplement (Medigap) Products
Plans offering a supplemental policy to fill "gaps" in Original Medicare coverage. A Medigap policy typically pays some or all of the deductible and coinsurance amounts applicable to Medicare-covered services, and sometimes covers items and services that are not covered by Medicare, such as care outside of the country. These plans are not affiliated or connected to Medicare.

Note: Scope of Appointment documentation is subject to CMS record retention requirements.