SCOPE OF SALES APPOINTMENT CONFIRMATION FORM

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the 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.

Please initial below beside the type of product(s) you want the agent to discuss.

	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)
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 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.	

By signing this form, you agree to a meeting with a sales agent to discuss the types of products 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, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: _____ **Signature Date:** _____

If you are the authorized representative, please sign above and print below:

Representative's Name: _____ *Your Relationship to the Beneficiary:* _____

To be completed by Agent:

Agent Name: _____ Agent Phone: _____

Beneficiary Name: _____ Beneficiary Email Address: _____

Initial Method of Contact: _____

Agent's Signature: _____

Plan(s) the agent represented during this meeting: _____

Date Appointment Completed: _____

Scope of Appointment documentation is subject to CMS record retention requirements

☐ If a telephonic scope of sales appointment was captured prior to the appointment please check here.

Agents, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting: _____

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