

Medicare Advantage Program: _____



Agent Checklist for Home Visits

Agent: _____ Person Visited: _____

Date: _____ Scope of Appointment: ☐ Yes ☐ No

Do you currently have a Power of Attorney (POA) or a Legal Representative authorized to make decisions on your behalf?
Yes ☐ No ☐

First Name	M.I.	Last Name	Telephone Number	Relationship
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Getting Started

- ☐ Enrollment into this Medicare Advantage Plan on contract renewal.
- ☐ Most people with ESRD are ineligible to enroll in a MA or MAPD program.
- ☐ Members must continue to pay their Medicare Part B premium.
- ☐ Members must reside within the plans service area.
- ☐ Members must have both Medicare Part A and B to enroll.
- ☐ Members can enroll only during specific times of the year.

Medical Summary of Benefits/Referrals

- ☐ PCP co-pays
- ☐ Specialists co-pays
- ☐ Hospital co-pays
- ☐ Other co-pays
- ☐ Referrals to Specialists
- ☐ Use of Network Providers

PCP Selection

Current Patient: ☐ Yes ☐ No

Other Benefits

- ☐ Silver Sneakers (If applicable)
- ☐ Preventative Dental
- ☐ Vision
- ☐ Transportation

Part D Pharmacy

- ☐ Formulary Tiers
- ☐ Pharmacy co-pays
- ☐ Initial Coverage Limit
- ☐ Gap Coverage
- ☐ TrOOP
- ☐ Use of Network Pharmacies
- ☐ Extra Help Eligibility

Presentation

- ☐ Video or company specific presentation shown

I understand that plan members must use plan (network) providers for routine care and that specialty care may require a referral from a network primary care physician.

Initial Here: _____

The person that is discussing plan options with you is contractor with the above provider, and may be compensated based on your enrollment in a plan. By signing this form, you acknowledge and attest that the information listed above has been adequately explained to you.

Beneficiary Signature

Date

Beneficiary Telephone Number

POA/Legal Representative Signature

Date

Agent Signature

Date