Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services (CMS) 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* beside the type of product(s) you want the agent to discuss.

Medicare Advantage Prescription Drug Plans (Part C) and Cost

☐ **Plans Medicare Preferred Provider Organization (PPO) Plan** — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and includes 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 Health Maintenance Organization (HMO) Plan** — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and includes Part D prescription drug coverage. With most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

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.

Additional Products ☐ Dental/Vision/Hearing ☐ Medicare Supplement (Medigap)

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: Please Print:**

Name:	**Phone:**
Address:	
Signature:	**Signature Date:**
If you are the authorized representative, please sign above and print below: Attach of Power of Attorney	
Representatives Name:	*Relationship to the Beneficiary:*

To Be Completed By Agent:

Agent Name:	Phone: 717-597-6977
Initial Method of Contact:(Indicate if beneficiary was a walk-in and/or explanation of why SOA was not documented prior to meeting:	
Agent Signature:	Date Appointment Completed:
Plan(s) the agent represented during conversation/meeting:	
Scope of Appointment (SOA) documentation is subject to CMS record retention requirement	