

Scope of Sales Appointment - Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment at least 48 hours prior to any individual 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 to discuss with the Licensed Sales Agent:

- _____ **Medicare Advantage Plans (Part C) and Cost Plans**
- _____ **Stand-alone Medicare Prescription Drug (Part D) Plan**
- _____ **Medicare Supplement (Medigap) Products**
- _____ **Dental-Vision-Hearing Products**
- _____ **Hospital Indemnity Products**

Refer to page 2 for product type descriptions listed.

BENEFICIARY OR AUTHORIZED REPRESENTATIVE SIGNATURE AND SIGNATURE DATE:

Signature of applicant/member/authorized representative (required):

Signature Date (required): MM/DD/YYYY

____/____/____

IF YOU ARE THE AUTHORIZED REPRESENTATIVE, PLEASE SIGN ABOVE AND PRINT BELOW:

Representative's Name (First, Last):

Relationship to the beneficiary:

By signing this form, you agree to a meeting with a Licensed Sales Agent to discuss the product(s) you initialed above. Please note, the Licensed Sales Agent 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 or future enrollment, or enroll you in a Medicare plan.

TO BE COMPLETED BY LICENSED SALES AGENT:

Agent Name: (required)

Agent Phone: (required)

Agent NPN:

Plan Assigned Agent ID:

Beneficiary Name: (required)

Beneficiary Contact Info (Phone or Address): (optional)

Initial method of contact (check): ☐ Sales Event ☐ Walk-In ☐ Inbound Call ☐ Permission to call

☐ Other (specify) _____

Plan(s) represented during this meeting:

Agent Signature:

Date of Appointment (required): MM/DD/YYYY

____/____/____

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 Cost 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 Medicaid Plan (MMP): An MMP is a private health plan designed to provide integrated and coordinated Medicare and Medicaid benefits for dual eligible Medicare beneficiaries.

Dental/Vision/Hearing Products

Plans offering additional benefits for consumers who are looking to cover needs for dental, vision or hearing. These plans are not affiliated or connected to Medicare.

Supplemental Accident and Health Products

Plans offering additional benefits; payable to consumers based on specified events; sometimes used to defray copays/coinsurance. These plans are not affiliated or connected to Medicare.

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.