Scope of Sales Appointment Confirmation Form

The Centers for Medicare & Medicaid Services requires agents to document the scope of a marketing appointment prior to any one-to-one 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.

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 (DSNP) — 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.
HMO Point-of-Service (HMO-POS) — A Medicare Advantage HMO plan that may allow you to get some services out-of-network for a higher copayment or coinsurance. It's important that you follow the plan's rules, like getting prior approval for a certain service when the plan requires it.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products 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.

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: **Date:**

Appointment 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 Phone (Optional):
Beneficiary Address (Optional):	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Agent's Signature:	
Plan(s) the agent represented during this meeting:	
Date Appointment Completed:	
[Plan Use Only:]	

*Scope of Appointment documentation is subject to CMS record retention requirements *

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

Kaiser Permanente complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.