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.
(Refer to page 2 for product type descriptions)

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

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

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

A Coordinated Care plan with a Medicare Advantage contract and a Medicare-approved Part D sponsor

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.

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.

Hospital Indemnity Products

Plans offering additional benefits; payable to consumers based upon their medical utilization; 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.

Date: _____ **Personal Information Sheet (one per person)** Referred by: _____

Name_____**DOB**_____**Phone**_____

Address_____**City**_____ **State**_____**Zip**_____

County_____ **Email**_____ **Tobacco Use last 12 months?**_____

Marital Status: ❒ Married ❒ Single, Live Alone ❒ Single, Live With Someone

What health coverage do you currently have? (Mark box that applies):

❒ **Individual** ❒ **Employer** ❒ **Retiree** **Plan Name**_____ **Drug Coverage Included**?_____

Do you have an HSA (Health Savings Account)? yes/no _____

❒ **Medicare Advantage Plan Name** _____(on your Insurance Card)

❒ **Medicare Supplement Company Name**_____ Plan(F, G, etc.) _____(on your Insurance Card)

AND Plan Name of Current Prescription Drug Coverage _____(on your Insurance Card)

Do you have Medicare?: ❒ Part A ❒ Part B ❒ **Mark here if you have a MyMEDICARE.gov** account set up

Veteran? (yes/no) _____ **Interested in a Plan with Health Club Membership?** (yes/no) _____

Current Pharmacy Name (VERY IMPORTANT) _____

❒ Mark here if you take NO medications ***OR*** ❒ My current medication list is attached (form provided)

NOTE: Some plans have Doctor networks, we want to check to see if your docs accept various plans

Primary Care Doctor_____Phone_____

Dentist/Practice _____Phone_____

Optometrist/Practice _____Phone_____

Specialist/Type_____Phone_____

Specialist/Type_____Phone_____

Specialist/Type_____Phone_____

Specialist/Type_____Phone_____

We will utilize a screen share to review your analysis. Please mark ALL devices you have available:

❒ PC/Laptop ❒ Mac ❒ iPad ❒ iPhone ❒ Android ❒ None

Return form to HealthCare Benefit Services
Mail: 6638 W. Ottawa Ave, Suite 120, Littleton, CO 80128
Fax: 720-287-7055, Email: info@HBSLTC.com (Email is not a secure form of communication.)
Phone: 303-973-6636 or **800-295-5860**

8/2/2023

Current Medication List

Your Name:_____ **Date**:_____

Complete Drug Name from Bottle/Container	**Dosage / Container Size** See list below	**Form** See list below	**Quantity Per Refill**	**Refill Frequency** See list below	**Generic OK** (Y)es or (N)o	**Using GoodRx*** (Y)es or (N)o
EXAMPLES						
Metoprolol Succinate ER	50mg	Tab	90	Q	Y	N
Albuterol Sulfate HFA	90mcg/8.5g	Inhaler	1	M	Y	Y

FORM: Tab Cap Inhaler Drops Patch Injection Vial Lotion Cream Ointment Gel

DOSAGE/SIZE: Be sure to list BOTH dosage and container size for Inhalers, Drops, Lotions, Creams, Ointments and Gels

REFILL FREQUENCY: (M)onthly (Q)uarterly (SA)Semi-Annually (A)nnually (BM)Every 2 months

DO NOT list "AS NEEDED" – Complete Refill Frequency with one of the above options

*Answer (Y)es if using GoodRx or any other discount drug plan to fill medication

Return form to HealthCare Benefit Services
Mail: 6638 W. Ottawa Ave, Suite 120, Littleton, CO 80128
Fax: 720-287-7055, Email: info@HBSLTC.com (Email is not a secure form of communication.)
Phone: 303-973-6636 or **800-295-5860**