

Scope of Sales Appointment Confirmation Form

The Centers for Medicare & Medicaid Services requires sales agents to document the scope of a marketing appointment at least 48 hours prior to any 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 the agent to discuss (required):
(refer to last page for product type descriptions)

_____ **Medicare Advantage Plans (Part C) and Cost Plans**
(initial here)

_____ **Stand-alone Medicare Prescription Drug Plans (Part D)**
(initial here)

_____ **Medicare Supplement (Medigap) Products**
(initial here)

Signature (required):

Signature Date (required): (____/____/____)
(MM/DD/YYYY)

If you are the Authorized Representative, please sign above and print below

Representative's Name:

Relationship to Beneficiary:

By signing this form, you agree to a meeting with a Sales Agent to discuss the product type(s) 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, impact your current or future Medicare enrollment status or automatically enroll you in the plan(s) to be discussed.

To be completed by Agent:

Agent Name (required):

Agent Phone (required):

Plan Assigned Agent ID:

Agent NPN:

Beneficiary Name (required):

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

Initial Method of Contact (check one): Sales Event Walk-In Inbound Call

Permission To Call Card Other (specify) _____

Plan(s) represented during this meeting:

Explanation required if SOA was not documented and signed at least 48 hours prior to the appointment:

Beneficiary requested next day or same day appointment

Beneficiary requested to discuss additional product types

Beneficiary did not have fax or mail to receive and return SOA before the appointment

Other (explain): _____

Agent Signature:

Date of Appointment (required):

(____/____/____)
(MM/DD/YYYY)

**IMPORTANT: Beneficiary Health Insurance Claim Number (HICN)
to be completed by Agent only after receipt of enrollment application**

Beneficiary HICN: