

## Scope of Sales Appointment Confirmation Form

The Centers for Medicare & 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 his/her 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.**

<p>_____ <b>Stand-alone Medicare Prescription Drug Plans (Part D)</b> Beneficiary initials</p>
<p><b>Medicare Prescription Drug Plan (PDP)</b> — 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.</p>
<p>_____ <b>Medicare Advantage Plans (Part C)</b> Beneficiary initials</p>
<p><b>Medicare Health Maintenance Organization (HMO) Plan</b> — 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).</p>
<p><b>Medicare Preferred Provider Organization (PPO) Plan</b> — 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.</p>

**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. The person does 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:* \_\_\_\_\_

**Required - to be completed by Agent:**

Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone (Optional):
Beneficiary Address (Optional):	
Medicare ID Number:	
Initial Method/Location of Contact: ( <input type="checkbox"/> 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: Ensure correct Scope of Appointment form is selected for beneficiary's plan enrollment choice. Also, if the form was signed by the beneficiary at the time of appointment, please provide explanation why SOA was not documented prior to meeting:

\_\_\_\_\_  
\_\_\_\_\_

The WellPoint-affiliated health plans are Medicare Advantage plans with Medicare contracts.

A Medicare-approved Part D sponsor.