



SCOPE OF SALES APPOINTMENT CONFIRMATION FORM

The Centers for Medicare and Medicaid Services requires licensed sales agents to document the scope of a marketing appointment prior to any individual 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 you want the agent to discuss.	
MedCare Partners Health Plan - Medicare Advantage Plans (HMO, HMO C-SNP):	
These Medicare Advantage Plans provide all Medicare Part A and Part B benefits, and all include Medicare Part D prescription drug coverage (MAPD). Some plans are designed for individuals with specific needs, such as those with chronic conditions (Chronic Condition Special Needs Plans, or C-SNPs).	
☐	Medicare Advantage HMO (Health Maintenance Organization): You must use doctors, hospitals, and other providers that are in the plan's network, except in emergencies. You must choose a primary care doctor, and you may be required to obtain referrals to see specialists.
☐	Medicare Advantage HMO Chronic Condition Special Needs Plans (HMO C-SNP): These plans are designed for people with specific chronic conditions, such as diabetes, cardiovascular disorders, or chronic heart failure. They tailor benefits, provider choices, and drug formularies to best meet the specific needs of the group they serve.

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By signing this form, you agree to a meeting with a licensed 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 NPN:
Agent Phone Number:	Agent Email:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address: <i>(optional)</i>	
Initial Method of Contact: <i>(Indicate here if candidate was a walk-in)</i>	
Agent Signature:	Date Appt. Completed: