Scope of Sales Appointment Confirmation Form

The Centers for Medicare and 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 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 mark beside the type of product(s) you want the agent to discuss.

Medicare Advantage Prescription Drug Plans (Part C) and Cost Plans

☐ **Medicare Preferred Provider Organization (PPO) Plan** — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and includes 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 Health Maintenance Organization (HMO) Plan** — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and includes Part D prescription drug coverage. With most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

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.

Additional Products

☐ **Dental/Vision**

☐ **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:	
Please Print:	
Name:	Phone:
Address:	
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:
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 (SOA) 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:

_____

_____

INSTRUCTIONS to complete Scope of Appointment

The Centers for Medicare & Medicaid Services (CMS)
For appointments on or after 10-1-23, CMS now requires all individuals meeting for Medicare to complete and return the following 2 page form **at least 48 hours PRIOR to a scheduled meeting** (exceptions can be made if time does not allow).

EACH individual MUST complete their own form.

Page 1) Please INITIAL ALL boxes
Page 2) Complete top section with your information, sign and date (YOU are the beneficiary)

Return Via:

- Fax: 717-208-6938
- Email: contact@landisfinancialadvisors.com
- Postal Mail: 3008 Columbia Ave., Lancaster, PA 17603

*If you have any questions, please telephone our office: 717-208-6990

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Please mark beside the type of product(s) you want the agent to discuss.

Medicare Advantage Prescription Drug Plans (Part C) and Cost Plans

INITIALS

JAD **Medicare Preferred Provider Organization (PPO) Plan** — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and includes 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.

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Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

SAMPLE

Beneficiary or Authorized Representative Signature and Signature Date:

Please Print:

Name: John A. Doe Phone: (717) 123-4567

Address: 123 Street Rd. Lancaster, PA 17601

Signature: X John A. Doe Signature Date: 9/30/2023

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:
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:]	

SAMPLE

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