Scope of Sales Appointment Confirmation Form

The Centers for Medicare & Medicaid Services (CMS) requires 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(s) you want the agent to discuss.

_____ **Medicare Advantage Prescription Drug Plans (Part C and D)**

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 Point of Service (HMO-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 healthcare provider. You can use doctors, hospitals, and providers outside of the network for an additional cost.

_____ **Dental / Vision / Hearing products**

Aspire Health Plan offers optional coverage for consumers who are looking for enriched dental, vision, and hearing benefits. This additional coverage is neither affiliated with nor endorsed by Medicare.

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.

No obligation to enroll, current or future Medicare enrollment status will not be impacted, and automatic enrollment will not occur.

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: _____

Please return this form to:
Aspire Health Plan
PO Box 5490
Salem, OR 97304

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:]

Scope of Appointment documentation is subject to CMS record retention requirements

Agent: If the form was signed by the beneficiary at time of appointment, provide explanation why Scope of Appointment was not documented prior to meeting.