Scope of Sales Appointment Confirmation Form

CareFirst Family of health care plans

The Centers for Medicare & Medicaid Services (CMS) requires agents to document the scope of a marketing appointment prior to any 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. If you do not want the agent to discuss a plan type with you, please leave the box empty.

☐ MEDICARE ADVANTAGE PLANS (PART C)

Medicare Preferred Provider Organization (PPO)—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.

☐ MEDICARE SUPPLEMENT (MEDIGAP) PLANS

Medicare Supplement (Medigap) Plans—Insurance plans that help pay some of the out-of-pocket costs not paid by Original Medicare (Parts A and B) such as deductibles and co-insurance amounts for Medicare approved services.

☐ MEDICARE SPECIAL NEEDS PLAN (SNP)

Medicare Special Needs Plan (SNP)—A Medicare Advantage Plan that has a benefit package designed for people with special healthcare needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

BENEFICIARY OR AUTHORIZED REPRESENTATIVE SIGNATURE AND SIGNATURE DATE

By signing this, you are agreeing to a sales meeting with a sales agent to discuss the specific types of products you initialed above. The person that will be discussing plan options with you is either employed or contracted by a Medicare health plan or prescription drug plan that is not the federal government, and they may be compensated based on your enrollment in a plan. Signing this does NOT obligate you to enroll in a plan, affect your current or future Medicare enrollment status, nor will it automatically enroll you in the plan(s) discussed.

By providing my phone number, I consent to receive calls from a representative of CareFirst BlueCross BlueShield about Medicare Advantage products, Medicare Supplement (Medigap) Plans and/or Medicare Supplement products at the number I have provided (include mobile devices). These calls may be made using an automated technology and my consent to receive these calls is not required as a condition for me to make a purchase.

BENEFICIARY OR AUTHORIZED REPRESENTATIVE SIGNATURE AND SIGNATURE DATE	
Beneficiary Phone (Optional):	
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:
Beneficiary Name:	
Initial Method of Contact (Indicate here if beneficiary was a walk-in.):	
Agent's Signature:	Agent NPN:
Plan(s) the agent represented during this meeting:	Date Appointment Completed:
Scope of Appointment (SOA) documentation is subject to CMS record retention requirements	
If the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to the meeting:	

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