# Scope of Appointment Confirmation Form

The Centers for Medicare and Medicaid Services (CMS) requires licensed sales agents to document the scope of the products that may be presented during a marketing appointment between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential. A separate form should be completed for each Medicare eligible beneficiary or his/her authorized representative.

**Please indicate the product(s) you agree to discuss by checking the applicable checkbox(es):**

- ☐ **Stand-alone Medicare Prescription Drug Plan**
- ☐ **Medicare Advantage Plans (Part C) and Cost Plans**
- ☐ **Dental/Vision/Hearing Products**
- ☐ **Hospital Indemnity Products**
- ☐ **Medicare Supplement or (Medigap) Products**

**By signing this form, you agree to a meeting with a licensed sales agent to discuss the types of products you indicated above.** Please note, the individual 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 or future 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 the Agent (print clearly and legibly):

| | | |
|---|---|---|
| Agent Name: | Agent Phone: | Agent Writing Number: |
| Beneficiary Name: | Beneficiary Phone (Optional): | Date Appointment will be Completed: |
| Beneficiary Address (Optional): | | |
| Initial Method of Contact: | Plan(s) the Agent will represent during the meeting | |
| Agent's Signature: | | |

*Scope of Appointment documentation is subject to CMS record retention requirements*

If applicable, provide the explanation why the SOA was not signed prior to meeting:

- ☐ Unplanned Attendee
- ☐ Walk-in
- ☐ Other (please explain): _____
- ☐ Beneficiary requested other health-related product information

# Product Descriptions

## 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.

## Medicare Advantage Plans (Part C) and Cost Plans

**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 HMO Point-of-Service (HMO-POS)** —A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. HMO-POS plans may allow you to get some services out of network for a higher copayment or coinsurance.

**Medicare Preferred Provider Organization (PPO) Plan** — 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 Private Fee-For-Service (PFFS) Plan** — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.

**Medicare Special Needs Plan (SNP)** — A Medicare Advantage Plan that has a benefit package designed for people with special health care 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.

**Medicare Medical Savings Account (MSA) Plan** — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

**Medicare Cost Plan** — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

## Other Health-Related Products

**Dental/Vision/Hearing Products** — Plans offering additional benefits for consumers who are looking to cover needs for dental, vision, or hearing. These plans **are not** affiliated or connected to Medicare.

**Hospital Indemnity Products**— Plans offering additional benefits; payable to consumers based upon their medical utilization; sometimes used to defray co-pays/co-insurance. These plans **are not** affiliated or connected to Medicare.

**Medicare Supplement (Medigap) Products**— 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 coinsurance amounts for Medicare approved services.

Southern Maine Retirement Services

Please provide the name of your doctor along with the office location and phone number.
If you see a Physician Assistant or Nurse Practicioner, please include the name of the Doctor under whom they practice.
List any durable medical equipment suppliers you use for items such as wheelchairs, braces, adaptive equipment, or CPAP machine supplies, etc.
This information is critical to our being able to accurately research the best plan options for you.

| Your Name: | | | | | | |
|---|---|---|---|---|---|---|
| **Primary Care** | | | | | | |
| Name | | | | | | |
| Address | | | | | | |
| | | | | | | |
| Phone | | | | | | |
| | | | | | | |
| **Eye Doctor** | | | | | | |
| Name | | | | | | |
| Address | | | | | | |
| | | | | | | |
| Phone | | | | | | |
| **Dentist** | | | | | | |
| Name | | | | | | |
| Address | | | | | | |
| | | | | | | |
| Phone | | | | | | |
| **Other Specialists** | | | | | | |
| Name | | | | | | |
| Address | | | | | | |
| Phone | | | | | | |
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Southern Maine Retirement Services

# Voluntary List of Prescriptions

In order for us to help you find a plan that suits your needs we ask that you volunteer an accurate list of your medications. Below is a list that you can fill in with the information we will need.

- Review your medication containers and write down exactly what is written on them.
- Include whether it is a Capsule or Tablet, Ointment or Cream, etc.
- Are you taking the Name Brand or the Generic? (Be sure to provide the generic name)
- If you are taking an extended release (ER) please indicate.
- If you use Insulin, please indicate the number of units you take and frequency (units per day).
- Be sure to include any medications that you take a few times a year—for example: inhalers, epi-pens, nasal sprays, ointments/creams/powders, etc.

**We cannot accept responsibility if you are denied coverage for any medication that you did not list on this page.**

**Your Name:**______________________________________________________________**Date:**____________________

**Current Drug Plan:**____________________________ **Pharmacy:**________________________________________

| **Medication Name** | | **Dosage** | **Times per Day** | **Refill Frequency** (circle one) |
|---|---|---|---|---|
| | Caps Cream<br>Tabs Oint.<br>Other ________ | | | once a month / every 3 months<br>twice a year / once a year |
| | Caps Cream<br>Tabs Oint.<br>Other ________ | | | once a month / every 3 months<br>twice a year / once a year |
| | Caps Cream<br>Tabs Oint.<br>Other ________ | | | once a month / every 3 months<br>twice a year / once a year |
| | Caps Cream<br>Tabs Oint.<br>Other ________ | | | once a month / every 3 months<br>twice a year / once a year |
| | Caps Cream<br>Tabs Oint.<br>Other ________ | | | once a month / every 3 months<br>twice a year / once a year |
| | Caps Cream<br>Tabs Oint.<br>Other ________ | | | once a month / every 3 months<br>twice a year / once a year |
| | Caps Cream<br>Tabs Oint.<br>Other ________ | | | once a month / every 3 months<br>twice a year / once a year |
| | Caps Cream<br>Tabs Oint.<br>Other ________ | | | once a month / every 3 months<br>twice a year / once a year |
| | Caps Cream<br>Tabs Oint.<br>Other ________ | | | once a month / every 3 months<br>twice a year / once a year |
| | Caps Cream<br>Tabs Oint.<br>Other ________ | | | once a month / every 3 months<br>twice a year / once a year |
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| | Caps Cream<br>Tabs Oint.<br>Other ________ | | | once a month / every 3 months<br>twice a year / once a year |
| | Caps Cream<br>Tabs Oint.<br>Other ________ | | | once a month / every 3 months<br>twice a year / once a year |

If your list continues, print off a second sheet and continue providing this information.

Required Disclaimer:

We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options.

Southern Maine Retirement Services

# Employer Insurance Questionnaire

- Do you have a large group health plan based on yours or your spouse's current employment?
- Will your insurance continue beyond age 65?
- Does your employer require you to enroll in Medicare?
- Have you confirmed the insurance is creditable (the drug coverage is at least as good as Medicare's)?
- Are there any other family members on your insurance?
- Will your employer compensate you if you come off of their insurance?
- What is your dollar amount share of the monthly premium? (with and without other covered members)
- What is your dollar amount share of the annual deductible? (with and without other covered members)
- What is your dollar amount share of the out-of-pocket maximum? (with and without other covered members)
- Do you typically meet your deductible or out of pocket maximum?
- Do you contribute to an HSA or HRA?
- What are your current prescription copays?

*Required Disclaimer:*
We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options.