# Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services 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 his or her authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his or her authorized representative.

In the boxes below, please put your initials beside the plan type that you want the agent to discuss with you. If you do not want the agent to discuss a plan type with you, please leave the box empty. (Please note that an agent may also discuss Medicare Supplement plans with you.)

| | |
|---|---|
| ☐ | **Standalone Medicare Prescription Drug Plans (Part D) (PDP)** – Standalone drug plans that add 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) (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 receive care only from doctors or hospitals in the plan's network (except in emergencies). May include optional supplemental dental HMO and PPO plan information. |
| ☐ | **Medicare Advantage Plans (PPO)** – A Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. PPO plans must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. May include optional supplemental dental PPO plan informmation. |
| ☐ | **Dental HMO, Dental PPO, or Dental + Vision plans** – Standalone plans that provide dental and vision coverage. Medicare has neither reviewed, nor endorses, these plans. |

**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:*

*Address (optional):*

*Phone number (optional):*

- -

*Your relationship to the beneficiary:*

MULTI-PLAN_19_360A_C 07232019

**By signing this form, you agree to a sales meeting with a sales agent to discuss the types of products you initialed above.**

**Please note, the person who will discuss the plan options is either employed by Blue Shield of California or contracted by a Medicare plan. They do not work directly for the Federal government. The 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 Medicare enrollment status, or automatically enroll you in the plan(s) to be discussed.**

**Beneficiary or authorized representative signature and signature date:**

| **Signature** | **Signature date** |
|---|---|
| | / / |

To be completed by the agent prior to meeting with beneficiary.

**Agent name** (required):

**Agent phone** (required):

**Plan assigned agent ID:**

**Agent NPN:**

**Beneficiary name (required):**

**Beneficiary contact info (phone or address (optional):**

- -

Initial method of contact (check one):

☐ Sales event ☐ Walk-in ☐ Inbound call ☐ Permission to call card ☐ Other

**Plan(s) the agent represented during this event/meeting:**

| **Agent signature (required):** | Date of appointment (required): |
|---|---|
| | / / |

By signing this form, Agent agrees and attests that this SOA was documented and agreed to by the beneficiary or their authorized representative prior to discussing plan information. Agent also agrees to provide a copy of this SOA when submitting the beneficiary's enrollment request. All SOA forms must be retained by the agent for no less than 10 years and be available to Blue Shield of California upon request regardless of whether or not the appointment resulted in an enrollment.

**IMPORTANT**: Beneficiary Medicare number to be completed by agent only after receipt of enrollment application.

**Beneficiary Medicare number:**

**Plan use only**

Send completed form by:

Mail to: Blue Shield of California, Medicare Installation and Membership, P.O. Box 948, Woodland Hills, CA 91365

Fax to: Blue Shield of California, Medicare Installation and Membership, **(877) 251-3660**

Agent, for additional information, call Blue Shield Producer Services at **(800) 559-5905** or your regional sales manager.

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

Blue Shield of California is an HMO, PPO, and PDP plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal.

Attention: If you speak language other than English, language assistance services, free of charge, are available to you. Call **(800) 559-5905** [TTY: 711].