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/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.)

☐	**Stand-alone Medicare Prescription Drug Plans (Part D) (PDP)** – Stand-alone 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 plan information.
☐	**Dental HMO, Dental PPO or Dental + Vision plans** – Stand-alone plans that provide dental and vision coverage. Medicare has neither reviewed, nor endorses, these plans.

By signing this form, you agree to a sales meeting with a sales agent to discuss the types of products you initialed above. The person who will be discussing plan options with you is contracted by a Medicare plan. They do not work directly for the Federal government. They 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:

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: _____

H0504_15_169B CMS Approved 07142015
H5609_15_169B CMS Approved 07142015
S2468_15_169B CMS Approved 07142015

To be completed by Agent:

Beneficiary name: _____

Beneficiary phone: _____

Beneficiary address: _____

Beneficiary e-mail (optional): _____

Initial method of contact (Indicate here if beneficiary was a walk-in):

_____

_____

Plan(s) the agent represented during this meeting: _____

_____

Date appointment completed: _____

If this Scope of Sales Appointment form is signed by the beneficiary at time of appointment, provide explanation why it was not documented prior to meeting:

_____

_____

_____

Agent name: _____

Agent phone: _____

Agent signature: _____

Date: _____ **Time:** _____

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 and PDP plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal.