



### 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 face-to-face 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.**

<input type="checkbox"/>	<b>Medicare Advantage Prescription Drug Plans (Part C &amp; D)</b>
<b>Medicare Health Maintenance Organization (HMO)</b> - 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).	
<b>Medicare Point of Service (HMO-POS) Plan</b> - 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 health care provider. You can use doctors, hospitals, and providers outside of the network for an additional cost.	
<input type="checkbox"/>	<b>Dental / Vision / Hearing Products</b>
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.

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: \_\_\_\_\_

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:**

Aspire Health Plan is a Medicare Advantage HMO plan sponsor with a Medicare contract. Enrollment in the Plan depends on contract renewal. Aspire Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-570-1600 (TTY: 711) 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電1-855-570-1600( TTY: 711)