

# Scope of Sales Appointment Confirmation Form



**Mail to:** Western Health Advantage, Medicare Sales  
2349 Gateway Oaks Drive, Suite 150, Sacramento, CA 95833

**Fax to:** 916.568.1338

**Questions?** 916.246.7494 | 888.992.7494 toll-free | 711 TTY

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 you want the agent to discuss.

### Medicare Advantage Prescription Drug Plans (Part C & D)

**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).

**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 or future enrollment, or enroll you in a Medicare plan.

### Beneficiary or Authorized Representative Signature and Signature Date:

Signature \_\_\_\_\_ Date \_\_\_\_\_

*If you are the authorized representative, please sign above and print below:*

Name \_\_\_\_\_

Relationship \_\_\_\_\_

**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:**

---

---

---

---

---

---

---

---

Western Health Advantage is a Medicare Advantage HMO plan sponsor with a Medicare contract. Western Health Advantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.