Harvard Pilgrim Health Care

Scope of Sales Appointment Confirmation Form for Harvard Pilgrim Health Care

The Centers for Medicare & 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 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 beside the type of product(s) you want the agent to discuss.

☐ Medicare Advantage Plans (Part C)

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).

☐ 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 Plan, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

☐ Medicare Supplement Plans

Medicare Supplement Plan — A Medicare Supplement plan fills the gaps in Original Medicare by paying the 20% of the Part B services not paid by Original Medicare. Plan option available with no deductibles or copayments/coinsurance once you pay your monthly premium. You may see any provider who accepts Original Medicare.

Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:

_____

_____

(Plan Use Only) **Application #** ☐☐☐☐☐☐☐

Scope of Appointment documentation is subject to CMS record retention requirements

Harvard Pilgrim is an HMO/HMO-POS plan with a Medicare contract. Enrollment in Stride℠ (HMO) depends on contract renewal. Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care and Harvard Pilgrim Health Care of New England.

Y0098_20203_C

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

Signature Date: (MM-DD-YYYY) ☐☐ ☐☐ ☐☐☐☐

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

Representative First Name I. Last Name

Your Relationship to Beneficiary:

To Be Completed by Agent:

Agent First Name I. Last Name

Agent Phone Number

Beneficiary First Name I. Beneficiary Last Name

Beneficiary Phone Number

Beneficiary Address (Optional)

Beneficiary City State Beneficiary Zip Code —

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: (MM-DD-YYYY) ☐☐ ☐☐ ☐☐☐☐