# Scope of Appointment Confirmation Form

Before meeting with a Medicare beneficiary (or their authorized representative), Medicare requires that Licensed Sales Representatives use this form to ensure your appointment focuses only on the type of plan and products you are interested in. A separate form should be used for each Medicare beneficiary. **Please check what you want to discuss with the Licensed Sales Representative.**

- ☐ **Medicare Advantage Plans (Part C) and Cost Plans**
- ☐ **Stand-alone Medicare Prescription Drug Plan (Part D)**
- ☐ **Medicare Supplement (Medigap) Plan**
- ☐ **Dental-Vision-Hearing Products**
- ☐ **Hospital Indemnity Products**

By signing this form, you agree to meet with a Licensed Sales Representative to discuss the products checked above. The Licensed Sales Representative is either employed or contracted by a Medicare plan and may be paid based on your enrollment in a plan. They **do not** work directly for the federal government.

Signing this form **does not** affect your current or future enrollment in a Medicare plan, enroll you in a Medicare plan or obligate you to enroll in a Medicare plan. All information provided on this form is confidential.

## Beneficiary or Authorized Representative Signature and Signature Date:

| Signature of applicant/member/authorized representative | Today's Date |
|---|---|
| X | 5/17/2006 |

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

| Name (First_Last) | Relationship to Beneficiary |
|---|---|
| adfa | adfadf |

## To be completed by Licensed Sales Representative (please print clearly and legibly)

| Licensed Sales Representative Name (First_Last) | Licensed Sales Representative Phone | Licensed Sales Representative ID |
|---|---|---|
| adf | adf | adf |
| **Beneficiary Name (First_Last)** | **Beneficiary Phone** | **Date Appointment will be Completed** |
| adf | adfadssf | adf |

Beneficiary Address

| Initial Method of Contact | Plan(s) the Licensed Sales Representative will Represent During the Meeting |
|---|---|
| daf | adf |

Licensed Sales Representative Signature

adf

## Medicare Advantage Plans (Part C) and Cost Plans

**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).

**Medicare HMO Point-of-Service (HMO-POS)** — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. HMO-POS plans may allow you to get some services out of network for a higher copayment or coinsurance.

**Medicare Preferred Provider Organization (PPO) Plan** — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors, providers and hospitals but you can also use out-of-network providers, usually at a higher cost.

**Medicare Private Fee-For-Service (PFFS) Plan** — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you — not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.

**Medicare Special Needs Plan (SNP)** — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

**Medicare Medical Savings Account (MSA) Plan** — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

**Medicare Cost Plan —** In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

## 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, some Medicare Cost Plans, some Medicare Private-Fee-For-Service Plans, and Medicare Medical Savings Account Plans.

## Other Related Products

**Medicare Supplement (Medigap) Products**— Insurance plans that help pay some of the out-of-pocket costs not paid by Original Medicare (Parts A and B) such as deductibles and co-insurance amounts for Medicare approved services.

**Dental/Vision/Hearing Products** — Plans offering additional benefits for consumers who are looking to cover needs for dental, vision, or hearing. These plans **are not** affiliated or connected to Medicare.

**Hospital Indemnity Products**— Plans offering additional benefits; payable to consumers based upon their medical utilization; sometimes used to defray copays/coinsurance. These plans **are not** affiliated or connected to Medicare.

BAACKE
INSURANCE & FINANCIAL SERVICES

OFFICE 941.907.4300
FAX 941.907.4301
WWW.BAACKEIFS.COM

7261 DELAINEY COURT
SARASOTA, FLORIDA 34240
PLAN RIGHT, RETIRE WELL

Name as it appears on your Medicare Card: _____DOB: _____

Medicare ID #: _____ Part A Date: _____ Part B Date: _____

Email: _____

Address: _____

Phone Number: _____

Current Rx Plan: _____

**Circle One: 30 Day Supply or 90 Day Supply**

Preferred Pharmacy_____

Second Preferred Pharmacy_____

**Who is your agent *(Please circle their name)?***

Brian Baacke ☑ Karin Botelho ☑ Bret Fuller ☑ Crystal Sudbury ☑ Kelli Soukup ☑

****Please include all prescriptions below. If you use drops, creams, ointments, insulin (pens or vials) or inhalers, please list under quantity taken daily how often and what size packaging you refill and the frequency. For insulin, how many boxes, pens, or vials you use each month?**

***Please Use NB for Name Brand Only***
***Example:***

***RxName ABC cream Strength 15% Howmany/day 30gramtube/3months***

RxName____XYZPill_____ Strength____20____Howmany/day _____1xperday_____

RxName_____ Strength_____Howmany/day _____

RxName_____ Strength_____Howmany/day _____

RxName_____ Strength_____Howmany/day _____

RxName_____ Strength_____Howmany/day _____

<CONTINUE ON BACK>

BAACKE
INSURANCE & FINANCIAL SERVICES

Rx Name_____Strength _____ How many/day _____

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**Please return the completed form to Baacke Insurance & Financial Services by mail or fax:**

**Address:** 7261 Delainey Court, Sarasota FL 34240

**Fax:** 941-907-4301

***Questions or concerns please contact us at 941-907-4300 or rx@baackeinsurance.com***

***If you have family, friends, co-workers that would like help, please have them contact us.***

***We are happy to help!***