Scope of Sales Appointment Confirmation Form

The Centers for Medicate 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 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.

☐ **Stand-alone Medicare Prescription Drug Plans (Part D)**

☐ **Medicare Advantage Plans (Part C) and Cost Plans**

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.

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 clearly and legibly below:	
Name (First_Last)	Relationship to Beneficiary

To be completed by Agent (please print clearly and legibly)		
Agent Name (First_Last)	Agent Phone	Agent ID
Beneficiary Name (First_Last)	Beneficiary Phone (Optional)	Date Appointment Completed
Beneficiary Address (Optional)		
Initial Method of Contact	Plan(s) the agent represented during the meeting	
Agent's Signature		
Scope of appointment (SOA) is subject to CMS Record Retention Requirements Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting: **Please check all that apply** ☐ Unplanned Attendee ☐ New SOA required (customer requested other Health Product Information) ☐ Walk in ☐ Other (please explain):		

2026

	NAME OF PRESCRIPTION	DOSAGE	STRENGTH
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			

Primary Care Physician:

Specialist:

Specialist:

Pharmacy:

Name:	**DOB:**
Address:	
City/State/Zip:	
County:	
Phone #:	
Email:	

Please visit us at: www.managedseniorservices.com

Armen Sharigian II
Managed Senior Services
4325 Cox Road
Glen Allen, VA 23060

Join Us On
facebook

office: 804.839.8385
toll free: 888.320.2664
fax: 804.285.1202
Armen@ManagedSeniorServices.com