MetroPlusHealth

SCOPE OF APPOINTMENT CONFIRMATION FORM

The Centers for Medicare and Medicaid Services requires Licensed Sales Representatives to document the scope of appointment prior to any individual sales meeting to ensure an understanding of what will be discussed between the Licensed Sales Representative and Medicare Beneficiary (or their authorized representative). A separate form should be used for each Medicare beneficiary. Please check what you want to discuss with the Licensed Sales Representative.

PLEASE INDICATE THE PRODUCT(S) YOU AGREE TO DISCUSS BY CHECKING THE APPLICABLE CHECKBOX(ES):

❑ **Medicare Special Needs Plan (HMO 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.

❑ **Medicaid Advantage Plus or MAP (HMO SNP): A Medicare Advantage Plan that has a benefit package designed for people with special health care needs.** A MAP plan is a type of integrated Dual-Eligible Special Needs Plan (D-SNP) combined with a type of Medicaid Managed Long-Term Care (MLTC) plan designed for people who have both Medicare and full Medicaid and who need a certain amount of health and community based long-term care services like home care and personal care in order to stay in their homes and communities as long as possible.

❑ **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 Licensed Sales Representative to discuss the types of products you checked above. Please note, the Licensed Sales Representative who will discuss the products is either employed or contracted by MetroPlus Health Plan and may 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. All information provided on this form is confidential.

BENEFICIARY OR AUTHORIZED REPRESENTATIVE SIGNATURE AND SIGNATURE DATE:

_____ _____ _____

Applicant's Printed Name *Applicant's Signature* *Date*

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

Your Relationship to the Beneficiary: _____

_____ _____ _____

Authorized Representative's Printed Name *Authorized Representative's Signature* *Date*

TO BE COMPLETED BY THE LICENSED SALES REPRESENTATIVE (PLEASE PRINT CLEARLY):

Licensed Sales Representative Name (First, Last): _____

Licensed Sales Representative Phone#: _____ Licensed Sales Representative ID#: _____

Beneficiary Name (First, Last): _____

Beneficiary Phone# (Optional): _____ Date Appointment will be Completed: _____

Beneficiary Address (Optional): _____

Initial Method of Contact: _____

_____ _____

Licensed Sales Representative's Signature *Date*