Scope of Appointment Confirmation Form

CareOregon Advantage

All information provided on this form is confidential and should be completed by each person with Medicare or their authorized representative.

Please initial below with your consent to speak about the plan type listed.

☐	**Medicare Advantage (Part C) and Medicare Advantage Prescription Drug Plans**
	Medicare Special Needs Plan (D-SNP) — A special type of Medicare Advantage Plan for people who are eligible for both Medicare and full Medicaid benefits.

Signing this form does NOT obligate you to enroll in a plan, affect your current or future enrollment, and will not automatically enroll you in a Medicare plan.

Beneficiary or authorized representative signature and signature date:

Signature _____ Signature time _____ Signature date _____

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

Representative's name _____ Your relationship to the beneficiary _____

To be completed by Agent:

Agent name:	Agent phone:
Beneficiary name:	Beneficiary phone:
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 and time 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 SOA was not documented prior to meeting: