预约范围确认表

本表格提供的所有信息均为保密信息，应由每个参保 Medicare 的人或其授权代表填写。

请在下面签上姓名首字母，表示您同意谈论列明的计划类型。

☐	**Medicare Advantage（C 部分）和 Medicare Advantage 处方药计划**
	Medicare 特殊需求计划 (D-SNP) —— 一项特殊类型的 Medicare Advantage 计划，适用于有资格获得 Medicare 和全部 Medicaid 福利的人。

签署本表格并非要求您参保计划，不会影响您当前或未来的参保，也不会让您自动参保 Medicare 计划。

受益人或授权代表签名和签名日期：

签名 | 签名时间 | 签名日期

如果您是授权代表，请在上面签名并在下面以正楷填写：

代表姓名 | 您与受益人的关系

由代理人填写：

Agent name:	Agent phone:
Beneficiary name:	Beneficiary phone:
Beneficiary address (optional)	
Initial method of contact: (Indicate here if beneficiary was a walk-in)	
Agents 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: