

Scope of Sales Appointment Confirmation Form

The Centers for Medicare 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 you want the agent to discuss.

Initial	Medicare Advantage Prescription Drug Plan
	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.

Medicare Advantage Plans (Part C) provide 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 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. This individual may also be paid based on your enrollment in a plan.

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: _____

Print Name: _____ Relationship to the Beneficiary: _____

To be Completed by Agent	
Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone (Optional):
Beneficiary Address (Optional):	
Initial Method of Contact (Indicate if beneficiary was a walk-in):	
Agent Signature:	

Plan Use Only

Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting.

Scope of Appointment documentation is subject to CMS record retention requirements

Nascentia Health Plus is an HMO SNP plan with a Medicare contract and a Coordination of Benefits Agreement with New York State. Enrollment in Nascentia Health Plus depends on contract renewal.



Enrollment Request Form to Enroll in a Medicare Advantage Plan (Part C) with Medicare Prescription Drug Plan (Part D)

Who can use this form?

People with Medicare and Medicaid who want to join a Medicare Advantage Plan

To join a plan, you must:

- › Be a United States citizen or be lawfully present in the U.S.
- › Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must have both:

- › Medicare Part A (Hospital Insurance)
- › Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- › Between October 15–December 7 each year (for coverage starting January 1)
- › Within 3 months of first getting Medicare
- › In certain situations where you're allowed to join or switch plans

Visit [Medicare.gov](https://www.Medicare.gov) to learn more about when you can sign up for a plan.

What do I need to complete this form?

- › Your Medicare number (the number on your red, white, and blue Medicare card)
- › Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional—you can't be denied coverage because you don't fill them out.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Reminders:

- › If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- › Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Nascentia Health Plus
1050 West Genesee Street
Syracuse, NY 13204

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Nascentia Health Plus at 888-477-4663 (TTY 711)

Or call Medicare at 1-800-MEDICARE (800-633-4227). TTY users can call 877-486-2048

En español: Llame a Nascentia Health Plus al 888-477-4663-/TTY 711 o a Medicare gratis al 800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- › If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., Social Security checks) may be considered your permanent residence address.



Section 1—All fields on this page are required (unless marked optional)

Select the plan you want to join:

- Nascentia Dual Advantage (003): \$0 per month
- Nascentia Skilled Nursing Facility (002): \$0 per month
- Nascentia Medicaid Advantage Plus (001): \$0 per month

FIRST name: _____ LAST name: _____ Middle Initial (Optional): _____

Birth date (MM/DD/YYYY): ___/___/____ Sex: Male Female

Phone: (____) _____-____-____ Email: _____

Permanent Residence Street Address (do not enter a PO Box): _____

City: _____ County (Optional): _____ State: _____ ZIP: _____

Mailing address, if different from permanent address (PO Box allowed):

Street Address: _____ City: _____ State: _____ ZIP: _____

Your Medicare information

Medicare Number: _____ - _____ - _____

Answer these important questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Nascentia Health Plus? Yes No

Name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage: _____

Are you enrolled in your state Medicaid Program? Yes No

If yes, please provide your Medicaid number: _____

IMPORTANT: Read and sign below

- › I must keep both Hospital (Part A) and Medical (Part B) to stay in Nascentia Health Plus.
- › By joining this Medicare Advantage Plan, I acknowledge that Nascentia Health Plus will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- › Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- › The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- › I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- › I understand that when my Nascentia Health Plus coverage begins, I must get all my medical and prescription drug benefits from Nascentia Health Plus. Benefits and services provided by Nascentia Health Plus and contained in my Nascentia Health Plus “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Nascentia Health Plus will pay for benefits or services that are not covered.
- › I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
 1. This person is authorized under state law to complete this enrollment, and
 2. Documentation of this authority is available upon request by Medicare

Signature _____ Today's Date _____

If you're the authorized representative, sign above and fill out these fields

Name _____ Address: _____

Phone Number: _____ Relationship to Enrollee: _____



Section 2—All fields on this page are optional

Answering these questions is your choice. You cannot be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- No, not of Hispanic, Latino/a, or Spanish origin Yes, Mexican, Mexican American, Chicano/a
 Yes, Puerto Rican Yes, Cuban
 Yes, another Hispanic, Latino/a, or Spanish origin
 I choose not to answer

What's your race? Select all that apply.

- American Indian or Alaska Native Asian Indian Black or African American
 Chinese Filipino Guamanian or Chamorro
 Japanese Korean Native Hawaiian
 Other Asian Other Pacific Islander Samoan
 Vietnamese White
 I choose not to answer.

Select one if you want us to send you information in an accessible format.

- Braille Large print Audio CD

Please contact Nascentia Health Plus at 1-888-477-4663 if you need information in an accessible format other than what's listed above. Our office hours are 7 days a week, 8am–8pm October 1–March 31. Monday–Friday, 8am–8pm the rest of the year. TTY users call 711.

Do you work? Yes No Does your spouse work? Yes No Not Applicable

List your primary care physician
(PCP), clinic, or health center:

Enrollee email address:

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or credit card each month. You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. **DO NOT** pay Nascentia Health Plus the Part D-IRMAA.

Privacy Act Statement: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.



Please read the following statements carefully and check the box if the statement applies to you.

By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

- | | |
|---|--|
| <input type="checkbox"/> I am new to Medicare | <input type="checkbox"/> I recently left a PACE program on
⇨ ___/___/____ |
| <input type="checkbox"/> I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) | <input type="checkbox"/> I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare’s). I lost my drug coverage on
⇨ ___/___/____ |
| <input type="checkbox"/> I recently moved outside of the service area for my current plan or I recently moved, and this plan is a new option for me. I moved on
⇨ ___/___/____ | <input type="checkbox"/> I am leaving employer or union coverage on
⇨ ___/___/____ |
| <input type="checkbox"/> I recently was released from incarceration. I was released on ⇨ ___/___/____ | <input type="checkbox"/> I belong to a pharmacy assistance program provided by my state |
| <input type="checkbox"/> I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on ⇨ ___/___/____ | <input type="checkbox"/> My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan. I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on ⇨ ___/___/____ |
| <input type="checkbox"/> I recently obtained lawful presence status in the United States. I got this status on
⇨ ___/___/____ | <input type="checkbox"/> I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on ⇨ ___/___/____ |
| <input type="checkbox"/> I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on
⇨ ___/___/____ | <input type="checkbox"/> I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on
⇨ ___/___/____ |
| <input type="checkbox"/> I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on ⇨ ___/___/____ | <input type="checkbox"/> I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency [FEMA]). One of the other statements here applied to me, but I was unable to make my enrollment because of a natural disaster. |
| <input type="checkbox"/> I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven’t had a change | <input type="checkbox"/> None of these statements apply to me or I’m not sure. Please contact Nascentia Health Plus to see if you are eligible to enroll at 888-477-4663/TTY 711, 8am–8pm seven days a week, Oct. 1–Mar. 31. From April 1–Sept. 30, M–F, our hours are 8am–8pm. |
| <input type="checkbox"/> I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on ⇨ ___/___/____ | |

Enrollee or authorized representative, sign and fill out information below

Signature	Date
-----------	------

Name	Phone
------	-------

Address	Relationship to Enrollee
---------	--------------------------

Office Use Only

Agent	Signature
-------	-----------

Plan ID #	Effective Date:	Date Received:
-----------	-----------------	----------------

ICEP/IEP

AEP

SEP (type)

Not Eligible

