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).

I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this Scope of Sales Appointment Form means that I have read and understand the contents of this form, I agree to meet with a sales agent and discuss the types of products initialed above, and understand that the person who will discuss the products is either employed or contracted by a Medicare plan and does not work directly for the federal government. Signing this form does NOT obligate me to enroll in a plan, affect my current enrollment, or enroll me in a Medicare Plan.

If signed by an authorized representative (as described above), this signature certifies that:

1. This person is authorized under state law to complete an enrollment, and
2. Documentation of this authority is available upon request by Medicare.

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.

OMB No. 0938-1378 Expires: 12/31/2026

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 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.

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 888-477-0090 (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 888-477-0090-/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.
- I understand that I can be enrolled in only one MA plan at a time - and that enrollment in this plan will automatically end my enrollment in another other MA plan (exceptions apply for MA PFFS, MA MSA plans).
- 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.
- 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 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:

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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.

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

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Nascentia Health Plus at 1-888-477-0090 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, and other:

I want to get the following materials via email.

☐ Enrollee email address:

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ Relationship to enrollee: _____

Signature: _____ National Producer Number (Agents/Brokers only): _____

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 ☐

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.

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Nascentia Health
TOMORROW'S HEALTHCARE TODAY

Authorization for Access to Patient Information Through Health Information Exchange Organizations

Patient Name	Date of Birth	Patient Identification Number
Other Names Used (e.g., Maiden Name):		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the organization named above to obtain access to my medical records through the following participating health information exchange organizations: Rochester RHIO, HealtheConnections, and Hixny. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network called the SHIN-NY. Rochester RHIO, HealtheConnections, and Hixny are not-for-profit organizations that share information about people's health electronically and meet the privacy and security standards of HIPAA and New York State Law. To learn more, visit these websites: www.RochesterRHIO.org http://healtheconnections.org www.hixny.org https://www.nyehealth.org/shin-ny/what-is-the-shin-ny/

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my bills. You can make that choice in a separate Consent Form that health insurers must use.

My Consent Choice. ONE box is checked to the left of my choice. I can fill out this form now or in the future. I can also change my decision at any time by completing a new form.

☐ **I GIVE CONSENT** for the organization named above to access ALL of my electronic health information through the SHIN-NY to provide health care services (including emergency care).

☐ **I DENY CONSENT** for the organization named above to access my electronic health information through the SHIN-NY for any purpose, **even** in a medical emergency (except for minor patients). **Unless you check this box, New York State law allows medical providers treating you in an emergency to get access to your medical records, including records that are available through the SHIN-NY**.

If I want to deny consent for all Provider Organizations and Health Plans participating in the Statewide Health Information Network for New York (SHIN-NY) that access my electronic health information through one of the following HIEs, I may do so by contacting each of the HIE's individually:

Rochester RHIO	www.RochesterRHIO.org	1-877-865-RHIO(7446)
HealtheConnections	http://healtheconnections.org	315-671-2241 x 5
Hixny	www.hixny.org	518-640-0021

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through the SHIN-NY and the consent process:

1. **How Your Information May be Used.**
   Your electronic health information will be used only for the following healthcare services:
   - **Treatment Services**. Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification**. Check whether you have health insurance and what it covers.
   - **Care Management Activities**. These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included.** If you give consent, the Provider Organization listed may access ALL of your electronic health information available through the SHIN-NY. This includes information created before and after the date this form is signed. Your health records may include clinical notes, discharge summaries, allergies, a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), treatments you have received, your diagnoses, and lists of medicines you have taken. These records may contain all of this information about sensitive health conditions, including but not limited to:

   - Alcohol or drug use problems**
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases

   ** If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3. **Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Rochester RHIO, HealtheConnections, and Hixny. You can obtain an updated list at any time by checking the websites of the participating organizations or calling them at the numbers on this form.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) who carry out activities permitted by this form as described above in paragraph one. If there is an emergency, doctors and other staff members will be able to use the SHIN-NY to see the health information of patients who are minors.

5. **Public Health and Organ Procurement Organization Access.** Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through the SHIN-NY for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization directly or visit the websites of Rochester RHIO, HealtheConnections, or Hixny; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/.*

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period.** This Consent Form will remain in effect until the day you withdraw or change your consent choice or until such time as Rochester RHIO, HealtheConnections, or Hixny cease operations (or until 50 years after your death whichever occurs first). If Rochester RHIO, HealtheConnections, or Hixny merge with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through the SHIN-NY while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form.** You are entitled to get a copy of this Consent Form.

Agent Checklist—Agent use only

Applicant Name:

Scope of Appointment Form

☐ Yes ☐ No	Was the Scope of Appointment (SOA) form completed? (This form must be agreed to by the beneficiary before any personal individual marketing appointment) If no, why not?
☐ Yes ☐ No	Is the PCP/facility in the Nascentia network? PCP/facility name:

Agent Information

Name of agent: Date of Enrollment:

Phone number:

Signature of agent:

Care Manager Questions

Current providers with addresses

Current list of medications

Diagnoses

Pharmacy:

If they are signed up with an MLTC, who is it:

What DME is in the home:

Any additional care manager questions/notes: