Borshoff & ASSOCIATES
Accountable Business Solutions for Your Future's Benefit

Doctor and Drug List

Name:		**Date of Birth:**	
Phone Number:		**Smoker:**	
Address:			
Email Address:			
Are you enrolled in Medicaid?	☐ **Yes** ☐ **No**		
Current Plan(s):		**Current Plan(s) $:**	
Medicare Claim #:		**Part A Effective Date:**	
Hospital Preference:		**Height:**	
Pharmacy Preference:		**Weight:**	

Doctor's Full Name	Address (At least Zip Code)

Full Medication Name (Note if Generic)	Dosage*	How Often	How Often You Fill Rx	Retail or Mail Order?

www.borshoff.com
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Phone: (317) 846-1005
Fax: (317) 846-0983

Full Medication Name (Note if Generic)	Dosage*	How Often	How Often You Fill Rx	Retail or Mail Order?

*If your medication is injectable (insulin) please put the number of vials or syringes you use each refill instead of units.

Notes

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What other benefits interest you?

- ☐ **Transportation**
- ☐ **Hearing Aids**
- ☐ **Life Alert System**
- ☐ **Dental**
- ☐ **Vision**
- ☐ **Over-The-Counter Drugs and Other Items**
- ☐ **Gym Membership**
- ☐ **Fitbit**
- ☐ **Meals after hospital stay**
- ☐ **Personal Home Helper***
- ☐ **Assistive Devices***
- ☐ **Virtual Visits**
- ☐ **Day Center Visits**
- ☐ **Service Dog Support**
- ☐ **Pest Control**
- ☐ **Healthy Nutrition**
- ☐ **Insulin Benefit**
- ☐ **Food Card**

* Requires help with 2 or more activities of daily living.

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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(s) you want the agent to discuss.

☐ **Stand-alone Medicare Prescription Drug Plans (Part D)**
Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.
☐ **Medicare Advantage Plans (Part C) and Cost Plans**
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).
Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.
Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.
Medicare Special Needs Plan (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 Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.
Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

A Medicare Advantage organization with a Medicare contract.

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:

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 (Optional):
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 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:

_____

_____

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