



DUNCAN MARKET INSURANCE

2022 Drug Card Review

Today's Date: _____

Return instructions below Thank you!

Client Name

Date of birth

primary home zip code and county

**Effective date
needed**

contact email

**contact phone
number**

Preferred Pharmacy:

Full name of current prescription	Dosage	Quantity Daily

Please,

Complete this form and the Scope of appointment

Submit the forms via email to info@duncanmarketins.com

Or Fax to 904-325-9323

Take a clear picture and text to 918-520-0952 or email to info@duncanmarketins.com

Sign up for **Clever RX** for more drug savings Partner.CleverRX.com/CarolynDuncan

Check prescription cost at this link, download the app, or scroll down and print an ID card for your use today.

Scope of Appointment Confirmation Form

Before meeting with a Medicare beneficiary (or their authorized representative), Medicare requires that Licensed Sales Representatives use this form to ensure your appointment focuses only on the type of plan and products you are interested in. A separate form should be used for each Medicare beneficiary. **Please check what you want to discuss with the Licensed Sales Representative.**

Please indicate the product(s) you agree to discuss by checking the applicable checkbox(es):

Medicare Advantage Plans (Part C) and Cost Plans

Dental-Vision-Hearing Products

Stand-alone Medicare Prescription Drug Plan (Part D)

Hospital Indemnity Products

Medicare Supplement (Medigap) Plan

By signing this form, you agree to meet with a Licensed Sales Representative to discuss the products checked above. The Licensed Sales Representative is either employed or contracted by a Medicare plan and may be paid based on your enrollment in a plan. They **do not** work directly for the federal government.

Signing this form **does not** affect your current or future enrollment in a Medicare plan, enroll you in a Medicare plan or obligate you to enroll in a Medicare plan. All information provided on this form is confidential.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature:

Signature Date:

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

Authorized Representative's Name:

Your Relationship to the Beneficiary:

To be completed by the Licensed Sales Representative (print clearly and legibly):

Licensed Sales Representative Name (First_Last)	Licensed Sales Representative Phone	Licensed Sales Representative ID
Beneficiary Name (First_Last)	Beneficiary Phone (Optional)	Date Appointment will be Completed
Beneficiary Address (Optional)		
Initial Method of Contact	Plan(s) the Licensed Sales Representative will represent during the meeting	
Licensed Sales Representative Signature		

Scope of Appointment documentation is subject to CMS record retention requirements