Patient
Name:___________________________

13923 W. Wainwright Ste. 301
Boise, Idaho 83713-1969

Denton R Roberts, MD

Insurance Signature on File

I request that payment of authorized Medicare/ Medicaid / Insurance benefits be made to me or on my behalf to Retinal Specialists of Idaho PLLC for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (or any other insurance payor) and its agents, any information needed to determine these benefits or the benefits payable for related services.

Date:_______________________________________

Signature:__________________________________