RETINA SPECIALISTS of Idaho, PLLC

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Denton R. Roberts, M.D. / James B. Earl, M.D., Ph.D. / Daniel J. Gealy, M.D.

Insurance Verification

Patient Name _____

Primary Insurance Company_____ ID #_____

Member Name_____ Date of Birth_____

Secondary Insurance Company_____ ID# _____

Member Name _____ Date of Birth _____

Tertiary Insurance Company_____ ID# _____

Member Name _____ Date of Birth _____

Are you currently on Hospice? Y N Starting date _____

Are you currently residing at a Skilled Nursing Facility? Y N

Date residence started _____

Name of Facility_____

Address _____

_____

Phone _____

Insurance Signature on File

I request that payment of authorized Medicare/ Medicaid / Insurance benefits be made to me or on my behalf to Retina 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.

Signature:_____ Date:_____