



13923 W. Wainwright Dr., Suite 301 / Boise, ID 83713-1969 / (208) 938-5624
128 E. Mallard Dr. / Boise, ID 83706-3975 / (208) 323-8660

Denton R. Roberts, M.D. / James B. Earl, M.D., Ph.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: _____