DANIEL H. COOK
ASSOCIATES INC

Vision Claim Form

Group Name: Bronxville Public School Employees' Benefit Trust

Patient Information

Please complete the member and patient information below.

Date(s) of Service

Member's Name

Member's Identification Number (Last 4 of SSN)

Address

City | **State** | **ZIP**

Patient's Name | **Patient's Date of Birth** | **Patient's Relationship to Member** (check one)

- ☐ Self
- ☐ Spouse
- ☐ Dependent

Vision Benefits

Benefit Payment for a Covered Person will be made as described in the Schedule of Benefits.

Services Rendered: *(Check the benefit(s) for which you are applying)*

- ☐ One set of lenses, including contacts lenses, covered once per Plan year
- ☐ Eye exam, covered once per plan year

- ☐ If you are using the Preferred Provider Vision Program through Raymond Opticians or Mendel Opticians, please check here.

*** ***Attach copy of provider's bill showing itemized services, fees, and date.*** ***

I certify that the information given is correct and authorize the release of any information necessary to process this claim.

Benefits are payable to the member only.

Member Signature **Date**

Mail Completed Form To:
Daniel H. Cook Associates, Inc.
1040 Avenue of the Americas,
24th Floor
New York, NY 10018

Fax Completed Form To:
(646) – 381 – 8853

Email Completed Form To:
intake@dhcook.com

Questions? You can call our Customer Service Department at (914) 250 – 0700.