DANIEL H. COOK
ASSOCIATES INC

Preferred Provider 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.
Please Note: *Services or supplies beyond which are listed may require having to pay the provider the difference.*

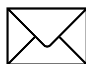
Services Rendered: ***(****Check the benefit(s) for which you are applying)*
- ☐ One set of lenses, including contacts lenses, covered once per Plan year
- ☐ Eye exam, covered once per plan year
- ☐ Other (Please list): ____

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

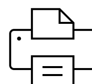
I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below-named billing optometry entity.

Member Signature **Date**

Billing Entity Information:
Name:
Address:



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.