MAIL COMPLETED CLAIMS TO

IUOE LOCAL 891 WELFARE FUND
C/O DANIEL H. COOK ASSOCIATES INC.
104 0A venue of the Americas, 24TH FLOOR
NEW YORK NY 10018
(212) 505-5050

HEARING AID VOUCHER

IF YOU GO PRIVATELY PLEASE RETURN THIS VOUCHER WITH PAID BILL

TO BE COMPLETED BY PROVIDER:

Name of Patient _____ Date of Birth _____

Date of Service _____ Total Charged _____

SERVICES RENDERED

I RECOMMEND THAT THIS PATIENT OBTAIN THE FOLLOWING TYPE OF HEARING AID:

☐ EXAM RECOMMENDED ☐ RIGHT EAR ☐ LEFT EAR ☐ BOTH EARS

BATTERY POWER _____ BRAND MODEL _____

SIGNATURE OF DOCTOR/PROVIDER _____

FIRM NAME _____

ADDRESS _____

MEMBER NAME _____ ACTIVE _____ RETIRED _____

ADDRESS _____

SIGNATURE OF MEMBER _____

TO RECEIVE PAYMENT FORM MUST BE FILLED OUT IN ITS ENTIRETY
ALSO SUBMIT COPY OF PROVIDER INVOICE FOR SERVICES RENDERED.