



DANIEL H. COOK
ASSOCIATES INC

Hearing Aid Claim Form

Group Name: Warwick Valley Teachers 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

Hearing Aid Benefits

Payment is limited to total of \$200.00 over a two-year period within the calendar years.

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

- ☐ Left Hearing Aid
☐ Right Hearing Aid
☐ Both

***** Attach copies of provider's bill showing itemized services, fees, and date.
Please do not send original copies *****

I certify that the above information is accurate and that the charges indicated were incurred by me or my dependents. I have not received payment for the amount of this claim from any other insurer, benefit fund, IRC 125 plan or by any other means.

Member Signature

Date



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



Email Completed Form To:

intake@dhcook.com

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