



DANIEL H. COOK
ASSOCIATES INC

Vision Claim Form

Group Name: Warwick Valley Teachers Benefit Trust

Patient Information

Please complete the member and patient information below.

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 vision allowance benefits.

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

Type of Service

Date of Service

Charge

☐ Exam

Lens

☐ Single Vision

☐ Bi-Focal

☐ Tri-Focal

☐ Progressive

☐ Contacts

☐ Frames

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

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

I Hereby Certify that the above statements
are correct and services are not covered by
other plans.

Member Signature

Date



Mail Completed Form To:
Daniel H. Cook Associates
1040 Sixth Ave 24th Floor
New York, NY 10018



Email Completed Form To:

intake@dhcook.com

Questions? You can call our Customer Service Department at (212) 505 – 5050.