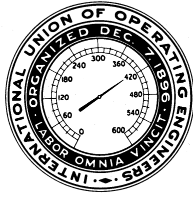
MAIL COMPLETED CLAIMS TO



IUOE LOCAL 891 WELFARE FUND
C/O DANIEL H. COOK ASSOCIATES INC.
253 WEST 35TH STREET 12TH FLOOR
NEW YORK NY 10001-1907
(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