PLEASE SIGN, AND FORWARD TO YOUR EMPLOYER

THANK YOU VERY MUCH

MORRISTOWN-HAMBLEN HOSPITAL

P. O. Box 1178 – Morristown, Tenn. 37814 – Area Code 615-586-4231

HOSPITAL INSURANCE FORM

Name of Insurance Company	Group Policyholder
COMPENSATION	RENAISSANCE PICTURES

Name of Policyholder or Group Certificate Holder	Policy Number(s)		
DONALD N. CAMPBELL			
Address–Street and Number	**City**	**State**	**Phone**
6180 EASTMOOR	BIRMINGHAM	MICHIGAN	581-8159
Name of Patient (if other than policyholder)		**Age**	**Relation**
SAME		22	SELF

Emergency Service – Date
11-15 -79

Other Insurance indicated by Hospital Records. If "yes", name of company.
☐ Yes ☑ No

Diagnosis From Records
CONTUSION/ABRASION RIGHT LATERAL THIGH

Nature of Surgical Procedure, If Any
DR. HUBBERT EXAMINED: PATIENT DISCHARGED WITH INSTRUCTIONS.

ATTENDING PHYSICIAN SS# [redacted] DR.D. HUBBERT **ADDRESS** P.O. BOX 1178 MORRISTOWN, TENN. 37814

HOSPITAL CHARGES

Emergency Room	$ 15.00
Laboratory	$
X–Ray	$
Medical & Surgical Supplies	$
Drugs	$
	$
	$
TOTAL	$ 15.00

NOTICE TO INSURANCE COMPANY

Morristown-Hamblen Hospital completes this form as a part of its regular service to patients who have hospitalization insurance. If additional information is needed beyond this routine service, such as additional forms completed or specific charges itemized, we will be happy to furnish it for $2.00 per form or per itemization, provided payment is submitted with the request for additional information. This policy is in keeping with our aim of providing service to our patients at the lowest cost possible.

If you need additional information please address correspondence to the Administrator.

HOSPITAL MORRISTOWN-HAMBLEN HOSPITAL ADDRESS P. O. Box 1178 – Morristown, Tenn. 37814

TAKEN FROM RECORDS ON 1 -3-80 SIGNED BY Peggy Seal Ins. Clerk

ASSIGNMENT OF INSURANCE BENEFITS & MAJOR MEDICAL: I hereby authorize and request all payment directly to the above named hospital of the hospital benefits herein specified and otherwise payable to me but not to exceed the hospital's regular charges for this service. I understand I am financially responsible to the hospital for charges not covered by this assignment.

DATE 10 Jan. '80 Signed Donald McCampbell
Insured

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above named hospital to release all information requested concerning my treatment.

DATE 10 Jan. '80 Signed Donald McCampbell
Patient (parent if minor)