# GROUP HOSPITAL INSURANCE REPORT

1. To _____ Coverage Confirmed by _____

_____ Date _____

Attention _____ Clerk _____

2. Name of Insurance Company JOHN HANCOCK INSURANCE CO.

*3. Name of Group Policyholder AMERICAN CYANIDE CO. (THRU MAC GREGOR LEAD CO.)

Address 4500 WEST 15TH STREET CHICAGO, ILLINOIS 60623

4. Name of Person Insured MR. CALVIN DAVIS

Address 637 NORTH LAWNDALE CHICAGO, ILLINOIS 60624

5. Name of Patient MAYDENE DAVID (MRS. CALVIN) Age 26

Relationship to Person Insured WIFE

6. Admitted to Hospital 11-18-71 (DATE) At _____ A.M. P.M.

7. Discharged 11-20-71 (DATE) At _____ A.M. P.M.

8. Diagnosis from Records: [redacted]

Operations or Obstetrical Procedures Performed: Nature & Date None

9. Type of accommodation: Private _____ Semi-private X Ward _____

ATTACH COPY OF ITEMIZED BILL

Hospital HOSPITAL/ PASSAVANT MEMORIAL

Address 303 EAST SUPERIOR STREET CHICAGO, ILLINOIS 60611

Taken from records on 11-26-71 (DATE)

CONFIDENTIAL INFORMATION REDACTED

Signed by Patricia Bennett

Title Butler

10. AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above-named hospital to release the information requested on this form.

Date 11-88-71 Signature X Maydene David

PATIENT'S SIGNATURE — (PARENT OR GUARDIAN IF PATIENT IS A MINOR)

11. ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment *directly* to the above-named hospital of the *hospital expense benefits otherwise* payable to me, but not to exceed the hospital's regular charges for this period of hospitalization. I understand that I am financially responsible to the hospital for the charges not covered by my Group Insurance Plan.

Date 11-18-71 Signature X Calvin Davis

(SIGNATURE OF PERSON INSURED)

*This form prepared and distributed by the Chicago Hospital Council*

REVISED APRIL 1, 1966

INSURANCE COPY

CYWI 4-001380

DETAIL OF SERVICES RENDERED

INSURANCE #1 COPY

# PASSAVANT MEMORIAL HOSPITAL

303 EAST SUPERIOR STREET. CHICAGO. ILLINOIS 60611

Northwestern University - McGaw Medical Center

41

| | | PATIENT NO. | SEX | AGE | DATES ADMITTED | DISCHARGED | CURRENT |
|---|---|---|---|---|---|---|---|
| PATIENT | MRS. DAVIS, MAYDENE | 45593 | F | 26 | 11/18/71 | 11/20/71 | 11/23/71 |

MAIL TO
MR. DAVIS, CALVIN
637 N LAWNDALE
CHICAGO IL 60624

TO INSURE PROPER CREDIT TO YOUR ACCOUNT, PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE.

AMOUNT OF REMITTANCE _____

| SOCIAL SECURITY NO. | FINANCE | MEDICARE |
|---|---|---|
| [redacted] | G | |

TEAR ALONG THIS PERFORATION

| | | POLICY NUMBER | PLAN NO. |
|---|---|---|---|
| 1ST INSURANCE COMPANY | JOHN HANCOCK | GROUP | 310 |
| 2ND INSURANCE COMPANY | | | |

| DATE MO. \| DAY \| YR. | REG. | ITEM | CODE | CHARGE DESCRIPTION | TOTAL CHARGE OR CREDIT | ESTIMATED INS. COVERAGE 1ST | 2ND | PAYABLE BY PATIENT |
|---|---|---|---|---|---|---|---|---|
| | | | | RM BOARD | 110.00 | | | |
| | | | | ANET O/R | .00 | | | [redacted] |
| | | | | X-RAY | .00 | | | |
| | | | | LAB | 2.46 | | | |
| | | | | MED SUPP | .00 | | | |
| | | | | PHARM | 8.20 | | | |
| | | | | BLOOD | .00 | | | |
| | | | | OTHER | 15.00 | | | |
| | | | | PAT MIS | .60- | | | |
| | | | | CASH | .60- | | | |

CONFIDENTIAL INFORMATION REDACTED

| PATIENT | | | 135.66 | 135.66 | | .00 |
|---|---|---|---|---|---|---|
| | | PATIENT NO. | TOTAL CHARGE OR CREDIT | ESTIMATED INS. COVERAGE 1ST | 2ND | PAYABLE BY PATIENT |

ADDITIONAL BILLING WILL BE SENT TO YOU FOR CHARGES NOT RECORDED AT THE TIME OF YOUR DISCHARGE.

NOTE: MINUS SIGN (–) INDICATES CREDIT.

PASSAVANT MEMORIAL HOSPITAL • CHICAGO, ILLINOIS

CYWI 4-001381

INSURANCE =1 COPY

DETAIL OF SERVICES RENDERED

# PASSAVANT MEMORIAL HOSPITAL

303 EAST SUPERIOR STREET, CHICAGO, ILLINOIS 60611
Northwestern University - McGaw Medical Center



| | PATIENT NO. | SEX | AGE | DATES ADMITTED | DISCHARGED | CURRENT |
|---|---|---|---|---|---|---|
| PATIENT: MRS. DAVIS, MAYDENE | 45593 | F | 26 | 11/18/71 | 11/20/71 | 11/23/71 |

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AMOUNT OF REMITTANCE _____

| SOCIAL SECURITY NO. | FINANCE | MEDICARE |
|---|---|---|
| [redacted] | G | |

TEAR ALONG THIS PERFORATION

| | | POLICY NUMBER | PLAN NO. |
|---|---|---|---|
| 1ST INSURANCE COMPANY | JOHN HANCOCK | GROUP | 310 |
| 2ND INSURANCE COMPANY | | | |

| DATE MO. \| DAY \| YR. | REG. | ITEM | CODE | CHARGE DESCRIPTION | TOTAL CHARGE OR CREDIT | ESTIMATED INS. COVERAGE 1ST | 2ND | PAYABLE BY PATIENT |
|---|---|---|---|---|---|---|---|---|
| 11/18/71 | 1 | | B | ROOM & BOARD RM 802-1 | 55.00 | | | |
| 11/19/71 | 1 | | B | ROOM & BOARD RM 802-1 | 55.00 | | | |
| 11/20/71 | 54 | 1 | S | EMERGENCY ROOM | 15.00 | | | |
| 11/22/71 | 61 | 99 | L | MED-SURG ADM SETS | 8.20 | | | |
| 11/20/71 | 80 | 44 | T | TELEPHONE | .60 | | | |
| 11/23/71 | 19 | 1 | N | ROUTINE URINALYSIS | 2.46 | | | |
| 11/20/71 | 91 | 3 | Z | PAYT-PATIENT | 60- | | | |

CONFIDENTIAL INFORMATION REDACTED

| PATIENT | PATIENT NO. | TOTAL CHARGE OR CREDIT | ESTIMATED INS. COVERAGE 1ST | 2ND | PAYABLE BY PATIENT |
|---|---|---|---|---|---|
| MRS. DAVIS, MAYDENE | 45593 | 135.66 | | | |

ADDITIONAL BILLING WILL BE SENT TO YOU FOR CHARGES NOT RECORDED AT THE TIME OF YOUR DISCHARGE.

NOTE: MINUS SIGN (-) INDICATES CREDIT.



CYWI 4-001382