MEDICAL LIEN NOTIFICATION AND CLAIM FORM

Claimant/Licensed Health Care Provider Information:

Name and Address of Claimant/Licensed Health Care Provider:
SUN RADIOLOGY
16222 N. 59th Ave Suite C-150, Glendale, AZ 85306
Phone: 623-815-8200
Officer or Authorized Agent of Health Care Provider: **SUN RADIOLOGY**

Claim Information:

To the best of the claimant's knowledge, the names and addresses of the persons, firms, or corporations, and insurance carriers claimed to be liable for damages are as follows:

Date of Lien Prepared: 11/17/2025
County: Maricopa
State: AZ

Patient Information:

Patient: ROSALIA CRUZ **DOB: 09/04/1985**
Address: 6017 S 23RD ST, PHOENIX AZ 85042
Law Firm Information

Law Firm Name: SOUTHWEST INJURY SPECIALIST
Firm Address: 301 E BETHANY HOME RD STE A-125, PHOENIX AZ 85012
Firm Phone Number: 602-922-9955

Date of Injury:

Date of Service Patients First Visit: 09/20/2025 - Present - Treating Continuing
Date of Full Release of Care: Ongoing

Amount Due Claimant for Care/Treatment: **$ 6,500.00 & ACCRUING:**

County and State in Which Injury or Illness Occurred: Maricopa County, AZ

Medical Lien Details:

Pursuant to A.R.S. 33-931 through A.R.S. 33-934, the above-named Claimant hereby claims a lien upon any and all causes of action, suits, claims, counterclaims, or demands for damages accruing to the above-named patient or to the legal representative, assignee, or heirs of such patient. This is a result of injuries giving rise to such causes of action that necessitated his/her treatment for the customary charges for health care treatment of the named patient in the sum herein above claimed to be due.

Affirmation:

I, ***Marc Ace***, being first duly sworn upon oath, depose and say:

- (1) I am an authorized agent of the claimant.
- (2) I have made this Notice & Claim of Medical Lien in good faith.
- (3) The facts herein stated are true and correct to the best of my knowledge.

X Rosalia Cruz
Patient Name

X
Claimant or Agent (Signature)