

Unofficial 20 Document

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Notice and Claim of Medical Care H-5 Law Forms 9-88, 12-90

Effective Date: 10-20-2025	County, State: Maricopa, Arizona
Licensed Health Care Provider: Patti Lehew, D.C., P.C. <ul style="list-style-type: none">• 9812 N 7th Street, Suite 7• PHOENIX AZ 85020•	Patient (Name, Address and Zip code): TORY WEEKS 18820 N 33RD AVE PHOENIX, AZ 85027
Licensed Health Care Provider Executive Officer or Agent of Health Care Provider: Patti Lehew, D.C., P.C. 9812 N. 7 th Street, Suite 7 Phoenix, AZ 85020-1763	
First Treatment Date: 10/06/2025	Last Treatment Date: Treatment Continues
Amount Due For Patient Care: Partial Liens \$690.00- Continues to increase	County in which injuries were sustained: Maricopa

Date(s) of which medical care and treatment were provided are 10/06/2025 to present. Patient continues to receive treatment and care.

To the best of claimant's knowledge the names and addresses of all persons, firms or corporations and the insurance carriers of said persons, firms or corporations claimed by the above named patient or by his or her legal representative, to be liable for damages are as follows:

LIBERTY MUTUAL
P.O. BOX 5014
SCRANTON, PA 18505

CLM# 060208358

The above-named claimants pursuant to the laws of the State of Arizona do hereby claim a lien upon any and all causes of action, suits, claims, counterclaims or demands accruing to the patient named herein or to the legal representative of such patient, on account of injuries giving rise to such causes of action and which necessitated his or her treatment, for the customary charges for health care and treatment of the above-named injured patient in the sum here in above claimed to be due. The name and address of the patient as herein before set forth are as the same appear on the records of the Licensed Health Care Provider.

WITNESSETH I am the Licensed Health Care Provider, Executive Officer or Agent of the Health Care Provider named in the foregoing Notice and Claim of Medical Care Lien and that I am the authorized to act on behalf of the said Health Care Provider and makes this Notice and Claim of Medical Lien for and on behalf of said Health Care Provider being thereunto duly authorized; that the matters and things contained in the foregoing Notice and Claim of Medical Care Lien are true.


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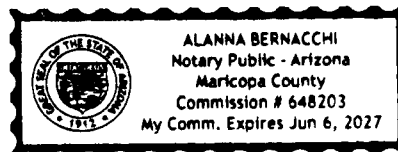
STATE OF ARIZONA)
County of Maricopa)ss


 Licensed Health Care Provider, Executive Officer or Agent

SUBSCRIBED AND SWORN this date: 10.20.25

June 6, 2027
 Notary Expiration Date


 Notary Public



(Continued on Reverse Side)