

Unofficial

20 Document

When recorded mail to:

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Name: \_\_\_\_\_

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City/State/Zip: \_\_\_\_\_

Area reserved for county recorder

*CAPTION HEADING:*

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710503400

**NOTICE OF HOSPITAL LIEN****ARIZONA REVISED STATUTES SECTIONS 33-931 through 937**

1. The undersigned hereby gives notice for and on behalf of Abrazo West Campus (hereinafter "Hospital") that the Hospital has furnished medical or other services to Tony Amaechi, an injured person who was injured in a motor vehicle or other liability accident. Pursuant to A.R.S. § 33-931, the Hospital claims a lien upon the recovery or sum had or collected or to be collected by the injured person identified below or by his or her heirs or personal representative, to the extent of the amount of the customary charges of the Hospital for the treatment, care and transportation of the injured person upon any judgment, settlement, or compromise.

2. Pursuant to the requirements of A.R.S. § 33-932, the Hospital submits the following information:

Name of Injured Person: Tony Amaechi

Address: 18843 W Adams St, Buckeye, AZ 85326

Dates of Service: 09/12/2025 - 09/12/2025

Name of Health Care Provider: **Abrazo West Campus**

Health Care Provider Address: 13677 West McDowell Road, Goodyear, AZ 85395

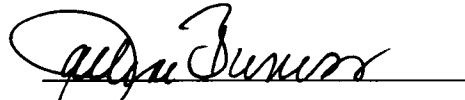
Amount Claimed Due: \$44,971.00

3. The amount claimed due as of the date of the recording of the Hospital's claim is \$44,971.00. To the best of the Hospital's knowledge, the <sup>Unofficial Document</sup> treatment by the Hospital for these injuries has been terminated.

Progressive, Claim # 25790978127, P.O. Box 94621 Cleveland, OH 44101

Tortfeasor: Unknown

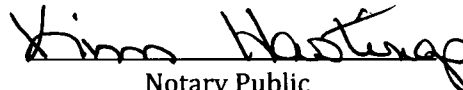
By:

  
Authorized Agent for the Hospital

STATE OF MISSISSIPPI

COUNTY OF ALCORN

The foregoing was acknowledged and verified before me on the date first written above by the duly authorized agent and/or operator of the Hospital identified herein, for on behalf of said Hospital:

  
Notary Public

