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NOTICE OF CLAIM OF HEALTHCARE PROVIDER LIEN

NAME AND ADDRESS OF HEALTH CARE PROVIDER:

CAS CHIROPRACTIC CENTER- 4619 N. 24TH ST. PHOENIX, AZ 85016

TAX ID#: 86-0778801

CAS MEDICAL CENTER-4619 N. 24TH ST. PHOENIX, AZ 85016

TAX ID# 82-3071898

NAME AND ADDRESS OF PATIENT:

MELODY MORRIS
19182 N SALERNO DR
MARICOPA, AZ 85138

CHART #12134 & 12135

DATE OF INJURY: 09/28/2025

DATES OF SERVICE: 11/12/2025 ; *AND CONTINUING AS PATIENT STILL TREATING.*

AMOUNT DUE: \$0- \$15,000 ; *PLUS, CHARGES ACCURING AS TREATMENT CONTINUES.*

To the best of claimant's knowledge, the names and address of all persons, firms or corporations and their insurance carriers claimed by the injured person or their legal representatives to be liable for damages arising from the injuries for which health care treatment has been received are as follows;

OTHER PARTIES NAMES:

NATIONAL GENERAL
CLAIM #250793245
PO BOX 1623
WINSTON SALEM, NC 27102

SEND COPY TO:

MELODY MORRIS
19182 N SALERNO DR
MARICOPA, AZ 85138

COPY TO ATTORNEY:

FARAR & LEWIS
20 E THOMAS RD STE 2200
PHOENIX, AZ 85012

Pursuant to the laws of the State of Arizona, ARS Chapter 7, Liens, Article 3, Health Care Provider Liens, 33-931 through 33-936, the above named claimant, personally or through its authorized agent, does hereby place a lien on any & all actions, suits, claims, counterclaims or demands for damages accruing to said patient on their behalf by a legal representative, assignee or heir on account of injuries giving rise to such cause of action and which is necessitated medical care & treatment for which claimant rendered such care at the rate customarily charged for such services as provided under ARS 33-931 (B), the sum of which is due and payable as indicated above. Claimant hereby demands that its name be placed on any and all settlement checks issued by the persons, firms, corporations or insurance carriers for their financial responsibility for all amounts under this lien.

STATE OF ARIZONA, COUNTY OF MARICOPA

I, Leticia Cervantes, being sworn upon oath, depose & say: (1) I am the Claimant or the Authorized Agent of Claimant; (2) I have made this Notice and Claim of Health Care Provider Lien in good faith; (3) The facts herein stated are true and correct to the best of my knowledge.

By Claimant or Agent: Leticia Cervantes

SUBSCRIBED AND SWORN to me on this 14 day of On November, 2025.

Notary Public: Carmen Chaparro Valenzuela

