When recorded mail to:

Name: _____

Address: _____

_____

City/State/Zip: _____

_____

20 Ki
Ho

this area reserved for county recorder

NOTICE OF CLAIM OF MEDICAL CARE LIEN:

DO NOT REMOVE

This is part of the official document.

Notice of Claim of Medical Care Lien

H-5 Law Forms 9-88, 12-90

Effective Date: 10/20/25	**County and State:** Maricopa, AZ
Licensed Health Care Provider: (Name, Address and Zip Code) Mohammad Awad, D.C. 201 W. Guadalupe Rd. Suite 201 Gilbert, AZ 85233	**Patient: (Name, Address and Zip Code)** Kianna Martinell: 4917 East Indian School Road Phoenix, Az 85018

Licensed Health Care Provider Executive Officer or Agent of Health Care Provider (Name, Address and Zip Code)

Pure Chiropractic Family LLC

Mohammad Awad, D.C.

201 W. Guadalupe Rd.

Suite 201

Gilbert, AZ 85233

First Treatment Date: 10/20/25

Last Treatment Date: Still under treatment

Amount Due for Patient Care:

$290

County in Which Injuries were Sustained:

Maricopa

Date(s) of which medical care and treatment were provided are:

10/20 ⟶ On going

To the best of the 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 as follows:

Patient name & address	Lien against & address
Kianna Martinelli	Travelers Property Casualty
4917 East Indian School Road	PO Box 650293
Phoenix, Az 85018	Dallas, Tx 75265-02983

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, suites, 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 hospital care and treatment of the above named injured patient in the sum herein above claimed to be due. The name and address of the patient as herein before set forth are the same as appeared on the records of the Licensed Health Care Provider.

WITNESSETH I am the Licenses Health Care Provider, Executive Office or Agent of the Health Care Provider named in the foregoing Notice and Claim of Medical Care Lien and that I am authorized to act 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.

STATE OF ARIZONA

COUNTY OF MARICOPA

Licensed Health Care Provider or Agent

Subscribed and Sworn on this date: October 23rd 2025

02/23/2029

Notary Expiration Date

Notary Public Signature

DANIEL STAZZONE
Notary Public - Arizona
Maricopa County
Commission # 680237
My Comm. Expires Feb 23, 2029