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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:	MICHELLE SMITH PO BOX 72742 PHOENIX, AZ 85050

CHART #12013
DATE OF INJURY: 03/02/2025

DATES OF SERVICE: 07/31/2025 ; ***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:	SEND COPY TO:
PROGRESSIVE CLAIMS CLAIM #25631209766 PO BOX 94670 CLEVELAND, OH 44101	MICHELLE SMITH PO BOX 72742 PHOENIX, AZ 85050 COPY TO ATTORNEY:

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 20 day of On November, 2025.

Notary Public- Carmen Chaparro Valenzuela

OFFICIAL SEAL
CARMEN CHAPARRO VALENZUELA
NOTARY PUBLIC - ARIZONA
MARICOPA COUNTY
COMM # 657642
My Comm. Expires November 2, 2027