

**MEDICAL LIEN NOTIFICATION AND CLAIM FORM**

**Claimant/Licensed Health Care Provider Information:**

Name and Address of Claimant/Licensed Health Care Provider:

**SUN RADIOLOGY**

16222 N. 59th Ave Suite C-150, Glendale, AZ 85306

Phone: 623-815-8200

Officer or Authorized Agent of Health Care Provider: **SUN RADIOLOGY**

**Claim Information:**

To the best of the claimant's knowledge, the names and addresses of the persons, firms, or corporations, and insurance carriers claimed to be liable for damages are as follows:

**Date of Lien Prepared: 10/14/2025**

County: Maricopa

State: AZ

**Patient Information:**

**Patient: ARMANDO DIMAS ROBLEDO**

**DOB: 12/18/1997**

**Address: 4630 E THOMAS RD APT G3, PHOENIX AZ 85018**

**Law Firm Information**

**Law Firm Name: SUNSHINE LAWYERS**

**Firm Address: 13590 SW 134<sup>TH</sup> AVE SUTIE 111, MIAMI, FL 33186**

**Firm Phone Number: 602-922-9955**

**Date of Injury: 08/30/2025**

**Date of Service Patients First Visit: 10/14/2025 - Present - Treating Continuing**

**Date of Full Release of Care: Ongoing**

**Amount Due Claimant for Care/Treatment: \$ 3,000.00 & ACCRUING:**

**County and State in Which Injury or Illness Occurred: Maricopa County, AZ**

**Medical Lien Details:**

Pursuant to A.R.S. 33-931 through A.R.S. 33-934, the above-named Claimant hereby claims a lien upon any and all causes of action, suits, claims, counterclaims, or demands for damages accruing to the above-named patient or to the legal representative, assignee, or heirs of such patient. This is a result of injuries giving rise to such causes of action that necessitated his/her treatment for the customary charges for health care treatment of the named patient in the sum herein above claimed to be due.

**Affirmation:**

I, Marc Ace, being first duly sworn upon oath, depose and say:

- (1) I am an authorized agent of the claimant.
- (2) I have made this Notice & Claim of Medical Lien in good faith.
- (3) The facts herein stated are true and correct to the best of my knowledge.

X Armando Dimas R

Patient Name (Signature)

X [Signature]

Claimant or Agent (Signature)

X \_\_\_\_\_

Attorney (Signature)