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Notice is hereby given that LAKESHORE HEALTH SYSTEM, INC d/b/a St. Catherine Hospital, whose principal address is 4321 Fir Street, East Chicago, Indiana, intends to hold a Hospital Lien for all reasonable and necessary charges for the hospital care, treatment or maintenance rendered to the Patient Named herein, in accordance with the provisions of I.C. 32-8-26-6, et. seq.. Said Lien shall attach to any cause of action, suit or claim accruing to said Patient, or in the event of the Patient's death, to his legal representative, because of the illness or injuries that gave rise to the cause of action, suit or claim, and necessitated the hospital care, treatment or maintenance referred to herein.

1. Patient Name and Address:	3739 DrummondSt, East Chicago, IN 46312
2. Operator of Hospital:	John Birdzell, 540 Tyler St. Gary, Indiana
3. Date Of Admission:	July 4, 1992
4. Date Of Discharge:	July 9, 1992 E
5. Amount Due For Hospital Cha	arges: \$4815.85 En Property States
or injury causing this Host	persons whom Patient hises in a his attorney claims is respon- amages arising from the illness pital Admission:
Name the Lake County Ro	ecordadiress
Metropolitan Life Insurance Co Group # 38016	PO: Box 2074 Aurora II 60507-2074 PO: Box 1870
Blue Cross/Blue Shield of Indiana Insurance ID No. 306747596	Indianapolis IN 46206
7. Name and Address of Patient	s Attorney: Unknown
E CONTRACTOR DE LA CONT	

I affirm, under the penalties for perjury, that I am authorized execute this instrument, and that the foregoing statements and representations are the and correct.

> LAKESHORE HEALTH SYSTEM, INC. d/b/a St. Catherine Hospital

arm Marie Ho, co By:

July 17, 1992 Insurance Billing Representative

Title:

CC: Indiana Department Of Insurance 311 West Washington Street, Suite 300 1Nulanapo118, Indiana 46204-2767

> This instrument Prepared By THE LAW OFFICES OF JANES E. DAUGHERTY 8550 Broadway Nerrillville, Indiana 46410