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**SWORN STATEMENT & NOTICE OF INTENTION TO HOLD HOSPITAL LIEN**

RECORDER

TO:           **KIISHANAKANTA RASTOGI**            
PATIENT:           **KIISHANAKANTA RASTOGI**            
          **#06604402**            
          **10326 SANDY LANE**            
          **MUNSTER, IND. 46321**          

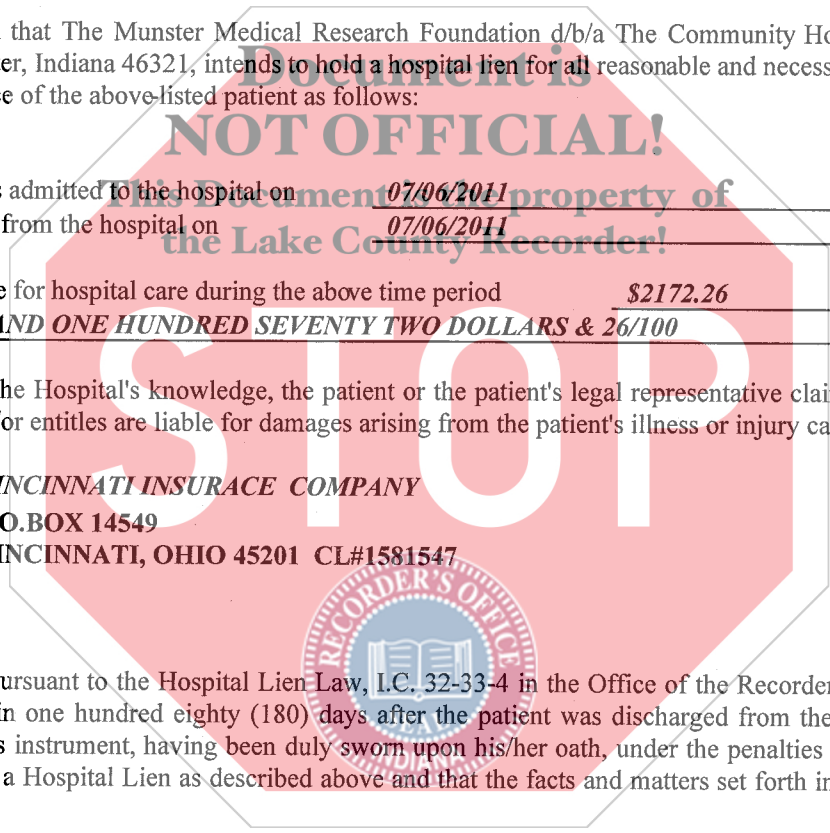
Recorder of Lake County, Indiana  
Lake County Government Center  
2293 North Main Street  
Crown Point, Indiana 46307

Indiana Department of Insurance  
311 West Washington Street  
Suite 300  
Indianapolis, IN 46204

You are hereby notified that The Munster Medical Research Foundation d/b/a The Community Hospital whose address is 901 MacArthur Blvd., Munster, Indiana 46321, intends to hold a hospital lien for all reasonable and necessary charges for hospital care, treatment, or maintenance of the above-listed patient as follows:

1. The patient was admitted to the hospital on           **07/06/2011**            
and discharged from the hospital on           **07/06/2011**
2. The amount due for hospital care during the above time period           **\$2172.26**            
          **TWO THOUSAND ONE HUNDRED SEVENTY TWO DOLLARS & 26/100**           DOLLARS
3. To the best of the Hospital's knowledge, the patient or the patient's legal representative claims that the following named individuals and/or entitles are liable for damages arising from the patient's illness or injury causing the hospital stay:

**CINCINNATI INSURANCE COMPANY**  
**P.O. BOX 14549**  
**CINCINNATI, OHIO 45201 CL#1581547**



This lien is being filed pursuant to the Hospital Lien Law, I.C. 32-33-4 in the Office of the Recorder of the County in which the hospital is located, within one hundred eighty (180) days after the patient was discharged from the hospital. The undersigned individual executing this instrument, having been duly sworn upon his/her oath, under the penalties of perjury hereby states that Claimant intends to hold a Hospital Lien as described above and that the facts and matters set forth in the foregoing statement are true and correct.

STATE OF INDIANA)  
COUNTY OF LAKE) SS:

          **PATRICIA J. BOOYER**          , being the collection clerk for the above named, The Community Hospital, being duly sworn upon his/her oath, says that the facts stated in the foregoing are true and correct.

          *Patricia J. Booyer*            
**PATRICIA J. BOOYER - PATIENT FINANCIAL SERVICES**

Subscribed and sworn to before me a Notary Public this           **2<sup>ND</sup>**           Day of           **AUGUST**           20           **11**          

My Commission Expires:           **02/14/17**            
Residing in Lake County, Indiana

          *Lisa E. Ward*            
**LISA E. WARD, Notary Public**

This instrument was prepared by PATRICIA J. BOOYER  
LIEN

AMOUNT \$           **11**            
CASH \_\_\_\_\_ CHARGE \_\_\_\_\_  
CHECK #           **045135**            
OVERAGE \_\_\_\_\_  
COPY \_\_\_\_\_  
NON-COM \_\_\_\_\_  
CLERK           **SS**