STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2013 089128

2013 DEC -4 AM 9:45

MICHAEL B. BROWN
RECORDER

SWORN STATEMENT & NOTICE OF INTENTION TO HOLD HOSPITAL LIEN
AMENDED 2013 078518

TO: ***KATHERINE ELKINS***

KATHERINE ELKINS PT.#3000600798
3000605166
12589 ROSE RD.
PLYMOUTH, IN 46563

ATTORNEY:

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 ***09/23/2013, 09/27/2013***
and discharged from the hospital on ***09/23/2013, 09/30/2013***

2. The amount due for hospital care during the above time period ***$11,957.52***
ELEVEN THOUSAND NINE HUNDRED FIFTY SEVEN AND 52/100 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 entities are liable for damages arising from the patient's illness or injury causing the hospital stay:

ALLSTATE INSURANCE
PO BOX 440519
KENNESAW, GA 30160
CL#030045315

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:

ALISON ADAMS, 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. I affirm under the penalties for perjury, that I have taken Reasonable care to redact each Social Security number in this document, unless requested by law.

ALISON ADAMS, PFS SUPPORT

Subscribed and sworn to before me a Notary Public this ***5TH*** Day of ***NOVEMBER*** 20 ***13***

My Commission Expires: *08/15/14*
Residing in Lake County, Indiana

GAYLE BRUMLEY, Notary Public

This instrument was prepared by ALISON ADAMS

AMOUNT $ 11
CASH ____ CHARGE ____
CHECK # 055333
OVERAGE ____
COPY ____
NON-COM ____
CLERK ____