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2014 FEB -4 PM 1:55

MICHAEL B. BROWN
RECORDER

Return to: Hospital Reimbursement Services, Inc.
250 Parkway Drive, Suite 168, Lincolnshire, IL 60069

SWORN STATEMENT & NOTICE OF INTENTION TO HOLD HOSPITAL LIEN

TO:
Patient:
Ms. Charisse A Dodds
154 S Indiana
Hobart, IN 46342

Attorney:



Lake County Recorder
2293 N. Main Street
Crown Point, IN 46307

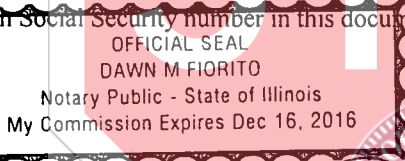
Indiana Department of Insurance
311 W Washington Street, Suite 300
Indianapolis, IN 46204

You are hereby notified that St. Anthony Hospital, Crown Point, 1201 S. Main St., Crown Point, IN 463078481, intends to hold a Hospital Lien for all reasonable and necessary charges for hospital care, treatment, or maintenance of the above-listed patient subject to the limits and reductions of any benefits to which the patient is entitled under the terms of any contract, health plan, or medical insurance.

Charisse A Dodds was a patient hospitalized on 11/08/13-11/09/13 due to an injury that occurred on 11/08/13. The total charges due for hospital care, treatment, or maintenance during the above hospitalization(s) is \$2,648.25, subject to all credits for payments, contractual adjustments, write offs and any other benefit in favor of the patient. The lien is reduced from total charges to limit the patient's financial obligation under the terms of any public or private benefits to which the patient is entitled. Patient's health insurance has denied reimbursement which may indicate that the entire balance is the patient's responsibility. Lienholder will amend lien to limit patient liability upon approval for payment by health insurer.

To the best of the Hospital's knowledge, the patient's legal representative that the following named individuals and/or entities are liable for damages arising from the patient's illness or injury causing the hospital stay: Ms. Monica Compton, State Farm Insurance, P.O. Box 661011, Dallas, TX 75266, Claim No.: 14366Q552.

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 ninety (90) days after the patient was discharged from the hospital. The undersigned individual executing this instrument, having been duly sworn upon oath, under the penalties of perjury hereby states that the hospital intends to hold the Hospital Lien as described above and that the facts and matters set forth in the foregoing state are true and correct, and that reasonable care has been taken to redact each Social Security number in this document, unless required by law.



St. Anthony Hospital, Crown Point

STATE OF ILLINOIS
COUNTY OF LAKE

BY:

Camille Zucchero
Camille Zucchero, As Agent

Subscribed and sworn to before me, a Notary Public, on _____, 2014, by Camille Zucchero, for and on behalf of said hospital.

Hospital Reimbursement Services, Inc., 250 Parkway Dr., Suite 168, Lincolnshire, IL 60069
Telephone 847-403-5870 | Facsimile 847-403-5871 | File No.: 14-70967

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