

NOTICE OF MEDICAL PROVIDER LIEN

Date: [Insert Date]

TO:

[Insurance Company Name or Law Firm Name]

[Address]

[City, State, Zip Code]

RE:

Patient Name: [Patient Name]

Date of Birth: [DOB]

Date of Incident/Injury: [Date]

Claim Number: [Claim Number, if known]

To Whom It May Concern:

Please be advised that [Medical Provider/Clinic Name] has provided medical treatment and services to the above-named patient for injuries sustained in the incident occurring on [Date of Incident].

Pursuant to [State Statute/Law], notice is hereby given that [Medical Provider/Clinic Name] hereby asserts a medical lien upon any and all claims, causes of action, settlements, or judgments resulting from the aforementioned incident. This lien is for the full cost of medical services rendered, as well as any future services provided for this injury.

The current outstanding balance for services rendered to date is \$[Amount].

Please acknowledge receipt of this lien in writing. You are further directed to include the name of [Medical Provider/Clinic Name] as a co-payee on any settlement check or payment issued in connection with this claim to ensure our interest is protected.

If this matter has already been settled or if you are no longer representing this individual, please notify our office immediately.

Sincerely,

[Authorized Signature]

[Name and Title]

[Medical Provider/Clinic Name]

[Phone Number]

[Email Address]