

# MEDICAL SERVICES LIEN

STATE OF OREGON \_\_\_\_\_ )  
 )  
COUNTY OF \_\_\_\_\_, SS:)

Notice is hereby given that \_\_\_\_\_ [insert name of medical service provider], whose address is \_\_\_\_\_ [insert address of service provider], has rendered hospitalization services or medical treatment to:

\_\_\_\_\_ [insert name of patient], of \_\_\_\_\_  
[insert address of patient]

a person who was injured on or about the \_\_\_ day of \_\_\_\_\_ in the city of \_\_\_\_\_, \_\_\_\_\_ State of Oregon. The hospitalization services or medical treatment was rendered to the injured person between the \_\_\_\_\_ day of \_\_\_\_\_ and the \_\_\_ day of \_\_\_\_\_ with the understanding that the injured person shall not be liable upon any money due or owing or any claim, compensation, or benefit payable to or for the injured person or judgment from any person or entity to have caused the injury, and any other person or entity liable for the injury, or be obligated to provide for the injured person or account for such injury.

The liability of the provider for payment for hospitalization services or medical treatment rendered to the injured person, including an insurer that provides personal injury protection coverage or similar no-fault medical insurance.

## STATEMENT OF AMOUNT DUE

Thirty days have not elapsed since the date on which the hospitalization services or medical treatment were last provided. The claimant's demand for said hospitalization services or medical treatment is in the sum of \$\_\_\_\_\_ and no part thereof has been paid, except \$\_\_\_\_\_, and there is now due and owing and remaining unpaid thereof, after deducting all credits and offsets the sum of \$\_\_\_\_\_, in which amount lien is hereby claimed.

\_\_\_\_\_  
Name of Claimant

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

**THIS IS A 3-PAGE FORM.**