CITY OF RIALTO
LIABILITY
CLAIM FOR DAMAGES TO PERSON OR PROPERTY

CITY CLERK'S DATE STAMP

CITY OF RIALTO
2024 OCT 23 PM 12:25
RECEIVED
CITY CLERK

1. *Claims for death, injury to person, or to personal property must be filed not later than six (6) months after the occurrence (Gov. Code §911.2).*
2. Claims for damages to real property must be filed not later than one (1) year after the occurrence (Gov. Code §911.2).
3. READ ENTIRE CLAIM FOR BEFORE FILING
4. ATTACH SEPARATE SHEETS, IF NECESSARY, TO GIVE FULL DETAILS

RETURN TO:
Rialto City Clerk's Office
Mail: 150 S. Palm Ave., Rialto, CA 92376
Address: 290 W. Rialto Ave., Rialto, CA 92376

CLAIMANT INFORMATION:

Maida Barrios
FULL NAME

DATE OF BIRTH

HOME ADDRESS INCLUDING CITY, STATE & ZIP

(888) 2637287 Ext 27758
HOME TELEPHONE NO.

P.O BOX 10730 Santa Ana, CA 92711-0730
BUSINESS ADDRESS INCLUDING CITY, STATE & ZIP

( )
BUSINESS TELEPHONE NO.

ADDRESS AT WHICH CLAIMANT DESIRES TO RECEIVE NOTICES OR COMMUNICATIONS REGARDING THIS CLAIM (if different from home address provided above):

1. **WHEN DID DAMAGE OR INJURY OCCUR?** DATE: 08/22/2024 TIME: ☐ AM ☐ PM

2. **PLACE OF ACCIDENT (OCCURRENCE) BE SPECIFIC** – *Describe fully and (if applicable) locate on diagram on reverse side of this sheet. Where appropriate, give street names and addresses, measurements and landmarks.*

ACACIA AVE / FOOTHILL BLVD right in front of the Bank of America.

3. **HOW DID DAMAGE OR INJURY OCCUR?**

THE OFFICER WAS COMING DOWN FOOTHILL FROM THE LEFT OF OUR INSURED, THE OFFICER WAS LOOKING DOWN AND SUN WAS IN HER EYES AND SHE STRUCK THE DRIVER SIDE REAR DOOR AND QUARTER PANEL OF OUR INSURED'S VEHICLE.

4. **WERE POLICE AT THE SCENE?** ☒ YES ☐ NO **WERE PARAMEDICS AT THE SCENE?** ☒ YES ☐ NO

5. **WHAT PARTICULAR ACT OR OMISSION DO YOU CLAIM CAUSED THE INJURY OR DAMAGES?** *Give the name of the city/town employee causing the injury or damage, if known.*

THE OFFICE FROM THE RIALTO POLICE HIT OUR VEHICLE.

6. **GIVE TOTAL AMOUNT OF CLAIM** *Include estimate of amount of any prospective injury or damage* $ 10,727.55

HOW WAS THE ABOVE AMOUNT COMPUTED? *Be specific, list doctor bills, repair estimates, etc.* ***Please attach 2 estimates.***

DAMAGES INCURRED TO DATE:

Item/Date: MEDICAL BILLS Amount: $ 8,052.97

Item/Date: Amount: $

TOTAL AMOUNT CLAIMED AS OF PRESENTATION OF THIS CLAIM: $ 18,780.52

ESTIMATED PROSPECTIVE DAMAGES, AS FAR AS KNOWN:

Item/Date: _____ Amount: $_____

Item/Date: _____ Amount: $_____

TOTAL ESTIMATED AMOUNT PROSPECTIVE DAMAGES: $_____

7. WITNESSES TO DAMAGE OR INJURY *List all persons known to have information (attach additional pages, if necessary)*

NAME: _____ NAME: _____

ADDRESS: _____ ADDRESS: _____

_____ _____

TELEPHONE: (___) _____ TELEPHONE: (___) _____

8. IF INJURED, PROVIDE NAME, CONTACT INFORMATION AND DATE/TIME DOCTOR(S) OR HOSPITAL(S) VISITED:

NAME: Arrowhead Radiology **NAME:** California Emergency Phy

ADDRESS: _____ ADDRESS: _____

_____ _____

TELEPHONE: (___) _____ TELEPHONE: (___) _____

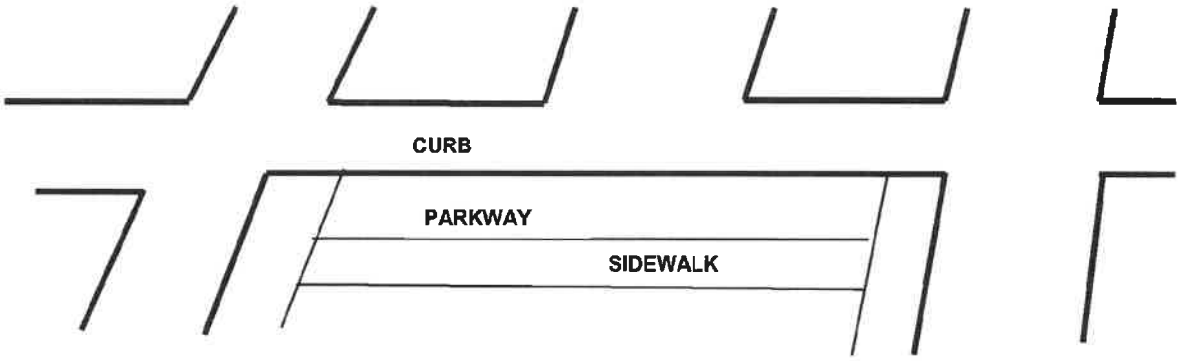
DATE: _____ TIME: _____ ☐ AM ☐ PM DATE: _____ TIME: _____ ☐ AM ☐ PM

9. PLEASE READ THE FOLLOWING CAREFULLY:

For all vehicle accident claims, place on the following diagram, the names of streets, including NORTH, EAST, SOUTH AND WEST directions. Indicate place of accident by "X" and by showing house numbers or distances to street corners.

If a city/town vehicle was involved, designate by letter "A" location of the City/Town vehicle when you first saw it, and by "B" location of yourself or your vehicle when you first saw City/Town vehicle; location of City/Town vehicle at time of accident by "A-1" and location of yourself or your vehicle at the time of the accident by "B-1" and the point of impact by "X".

⇨ ***NOTE: IF THE DIAGRAM BELOW DOES NOT FIT THE SITUATION, PLEASE ATTACH A PROPER DIAGRAM SIGNED BY THE CLAIMANT.***



I HAVE READ THE FOREGOING CLAIM AND KNOW THE CONTENTS THEREOF; AND CERTIFY THAT THE SAME IS TRUE OF MY OWN KNOWLEDGE EXCEPT AS TO THOSE MATTERS WHICH ARE HEREIN STATED UPON MY INFORMATION AND BELIEF; AND AS TO THOSE MATTERS I BELIEVE THEM TO BE TRUE.

I CERTIFY (OR DECLARE) UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.

_____
SIGNATURE OF CLAIMANT OR AGENT

Andrew Ortega
TYPE OR PRINT NAME

10/21/24
DATE

Adjustor
RELATIONSHIP TO CLAIMANT

NOTE: PRESENTATION OF A FALSE CLAIM IS A FELONY (CA PENAL CODE 72)
RETURN CLAIM TO: RIALTO CITY CLERK'S OFFICE – 150 S. PALM AVE., RIALTO, CA 92376

Hi this is Maida Barrios

Recently send me a mailing of my letters

STATEMENT

01570

vituity

Account Information

CEP AMERICA CALIFORNIA

Tax Id:

Location of Service: ARROWHEAD REGIONAL MED CTR

Rendering Provider: NEWTON, ERNEST, P.A.

Statement Date: 09/30/24

Account #: E80

Patient Amount Due: $340.17

MULTIPLE WAYS TO PAY

SCAN FOR MOBILE PAYMENT or to enter your insurance information

Online www.ePayitOnline.com
Code ID: VITUBIL1 Access#: 15931835-1-2488

Phone (866) 954-4405, International # (209) 252-0601

Mail Use the detachable Payment Stub below and enclosed return envelope

pay **Pay with a picture in seconds!**
Search Papaya Payments in the App Store or go to www.ppaya.com/pay

App Store Google Play

Primary Insurance: ANTHEM BLUE CROSS CAREL Secondary Insurance:

Date of Service		Description of Services	Charges	Payments	Adjustments	Amount Due
08/22/24	99285	EMERGENCY DEPT VISIT HIGH MDM	$1,224.00			
09/23/24		CARRIER PAYMENT		$179.10–		
09/23/24		CARRIER ADJUSTMENT			$704.73–	
		Total:				$340.17

YOUR INSURANCE HAS APPLIED THEIR PAYMENT TOWARD YOUR YEARLY DEDUCTIBLE. THE BALANCE DUE IS YOUR RESPONSIBILITY. THANK YOU.

SU SEGURO MEDICO HA APLICADO EL SALDO DE SU CUENTA A SU DEDUCTIBLE ANNUAL. EL SALDO RESTANTE ES SU RESPONSABILIDAD. GRACIAS

If uninsured or with high medical expenses, you may qualify for a discount, payment plan or Medicaid Program; please contact our office for assistance. If you have insurance, you can submit information via our secure portal at www.epayitonline.com or fill out the back of this form and submit it to billing@vituity.com

Si no tiene seguro medico o tiene gastos médicos altos, puede calificar para un descuento, un plan de pago o un programa de Medicaid; Por favor de comunicarse con nuestra oficina para obtener ayuda. Si tiene seguro medico, puede enviar información a través de nuestro portal seguro www.epayitonline.com o completar el reverso de este formulario y enviarlo a billing@vituity.com

Contact Us

billing@vituity.com
or
(800) 498-7157
6 am - 5:30 pm PST

AMOUNT DUE
$340.17

Please detach and return the bottom portion with payment

CEP AMERICA CALIFORNIA
PO BOX 582663
MODESTO CA 95358-0046

vituity

epayitonline.com
Easiest way to view your statement, make payments, set up a payment plan or submit insurance information

STATEMENT DATE	ACCOUNT #	AMOUNT DUE
09/30/24		$340.17

Patient: MAIDA BARRIOS

MAKE CHECK PAYABLE AND REMIT TO:

01570

MAIDA BARRIOS

CEP AMERICA CALIFORNIA
PO BOX 582663
MODESTO CA 95358-0046

vituity

Account Information

CEP AMERICA CALIFORNIA

Tax Id: [redacted]

Location of Service: ARROWHEAD REGIONAL MED CTR

Rendering Provider: JOHNSON, STEVEN, D.O.

Statement Date: 09/30/24

Account #: [redacted]

Patient Amount Due: $103.85

MULTIPLE WAYS TO PAY

SCAN FOR MOBILE PAYMENT or to enter your insurance information

Online www.ePayitOnline.com Code ID: VITUBIL1 Access#: 15931835-1-2489

Phone (866) 954-4405, International # (209) 252-0601

Mail Use the detachable Payment Stub below and enclosed return envelope

pay **Pay with a picture in seconds!** Search Papaya Payments in the App Store or go to www.ppaya.com/pay

App Store Google Play

01571

Primary Insurance: ANTHEM BLUE CROSS CAREL Secondary Insurance:

Date of Service		Description of Services	Charges	Payments	Adjustments	Amount Due
08/27/24	99285	EMERGENCY DEPT VISIT HIGH MDM	$1,224.00			
09/23/24		CARRIER PAYMENT		$415.42–		
09/23/24		CARRIER ADJUSTMENT			$704.73–	
		Total:				$103.85

YOUR INSURANCE HAS PAID THEIR PORTION OF THE ABOVE CHARGES. THE BALANCE DUE IS YOUR RESPONSIBILITY. THANK YOU

SU SEGURO MEDICO HA PAGADO SU PORCION. EL SALDO RESTANTE ES SU RESPONSABILIDAD. GRACIAS

CITY OF RIALTO
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2024 OCT 23 PM 12:25

If uninsured or with high medical expenses, you may qualify for a discount, payment plan or Medicaid Program; please contact our office for assistance. If you have insurance, you can submit information via our secure portal at www.epayitonline.com or fill out the back of this form and submit it to billing@vituity.com

Si no tiene seguro medico o tiene gastos médicos altos, puede calificar para un descuento, un plan de pago o un programa de Medicaid; Por favor de comunicarse con nuestra oficina para obtener ayuda. Si tiene seguro medico, puede enviar información a través de nuestro portal seguro www.epayitonline.com o completar el reverso de este formulario y enviarlo a billing@vituity.com

Contact Us

billing@vituity.com
or
(800) 498-7157
6 am - 5:30 pm PST

AMOUNT DUE

$103.85

Please detach and return the bottom portion with payment.

CEP AMERICA CALIFORNIA
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vituity

epayitonline.com

Easiest way to view your statement, make payments, set up a payment plan or submit insurance information

STATEMENT DATE	ACCOUNT #	AMOUNT DUE
09/30/24	[redacted]	$103.85

Patient: MAIDA BARRIOS

MAKE CHECK PAYABLE AND REMIT TO:

01571

MAIDA BARRIOS
[redacted]

CEP AMERICA CALIFORNIA
PO BOX 582663
MODESTO CA 95358-0046

CalPERS

P O BOX 70000
VAN NUYS, CA 91470-0001

EXPLANATION OF BENEFITS

024452

ISSUE DATE	PAGE
September 14, 2024	00001 OF 00003

Subscriber's Name: MAIDA BARRIOS
Identification Number: [redacted]
Group Number: DB250I
Group Name: CALPERS PERS GOLD ACTIVES(PA) REGION3
Product: Medical Plan

32

MAIDA BARRIOS
[redacted]

01E7570201O1

Patient's Name: MAIDA BARRIOS
Claim Number: [redacted]
Claim Processed Date: 09/11/24

Sequence Number: 1306899166 202400274
Provider of Services: CALIFORNIA EMERGENCY PHYS
Place of Service: Outpatient
Patient Acct. Number: [redacted]

Paid Amount: $179.10 To: CALIFORNIA EMERGENCY PHYS

It is your responsibility to pay: $340.17 It is not your responsibility to pay: $704.73

Thank you for using a Network Participating Provider.

SERVICE DATE(s)	TYPE OF SERVICE	TOTAL BILLED	OTHER AMOUNT(S)	PATIENT SAVINGS	APPLIED TO DEDUCTIBLE	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
08/22/24	Emergency Service	1,224.00		704.73/01	295.39/02	44.78/03	179.10
	TOTAL THIS CLAIM	1,224.00	0.00	704.73	295.39	44.78	179.10

Patient's Name: MAIDA BARRIOS
Claim Number: 24254FC8955
Claim Processed Date: 09/11/24

Sequence Number: 1306899166 202400274
Provider of Services: CALIFORNIA EMERGENCY PHYS
Place of Service: Outpatient
Patient Acct. Number: E8000121586001

Paid Amount: $415.42 To: CALIFORNIA EMERGENCY PHYS

It is your responsibility to pay: $103.85 It is not your responsibility to pay: $704.73

Thank you for using a Network Participating Provider.

SERVICE DATE(s)	TYPE OF SERVICE	TOTAL BILLED	OTHER AMOUNT(S)	PATIENT SAVINGS	APPLIED TO DEDUCTIBLE	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
08/27/24	Emergency Service	1,224.00		704.73/01		103.85/03	415.42
	TOTAL THIS CLAIM	1,224.00	0.00	704.73	0.00	103.85	415.42

Member's Medical Deductible Applied to Date: $500.00

CAEAP516 COMB 20240917801 J39C

CalPERS P O BOX 70000
VAN NUYS, CA 91470-0001

024871

EXPLANATION OF BENEFITS

ISSUE DATE	PAGE [redacted]
September 7, 2024	00001 OF 00003

Subscriber's Name: MAIDA BARRIOS
Identification Number: [redacted]
Group Number: DB250I
Group Name: CALPERS PERS GOLD ACTIVES(PA) REGION3
Product: Medical Plan

*******************ALL FOR AADC 923
9841 1 AB 0.593 32
MAIDA BARRIOS
[redacted]

0135710201013

Patient's Name: MAIDA BARRIOS
Claim Number: [redacted]
Claim Processed Date: 09/04/24
Sequence Number: 1023113172 202400028
Provider of Services: ARROWHEAD RADIOLOGY MEDIC
Place of Service: Outpatient
Patient Acct. Number: [redacted]

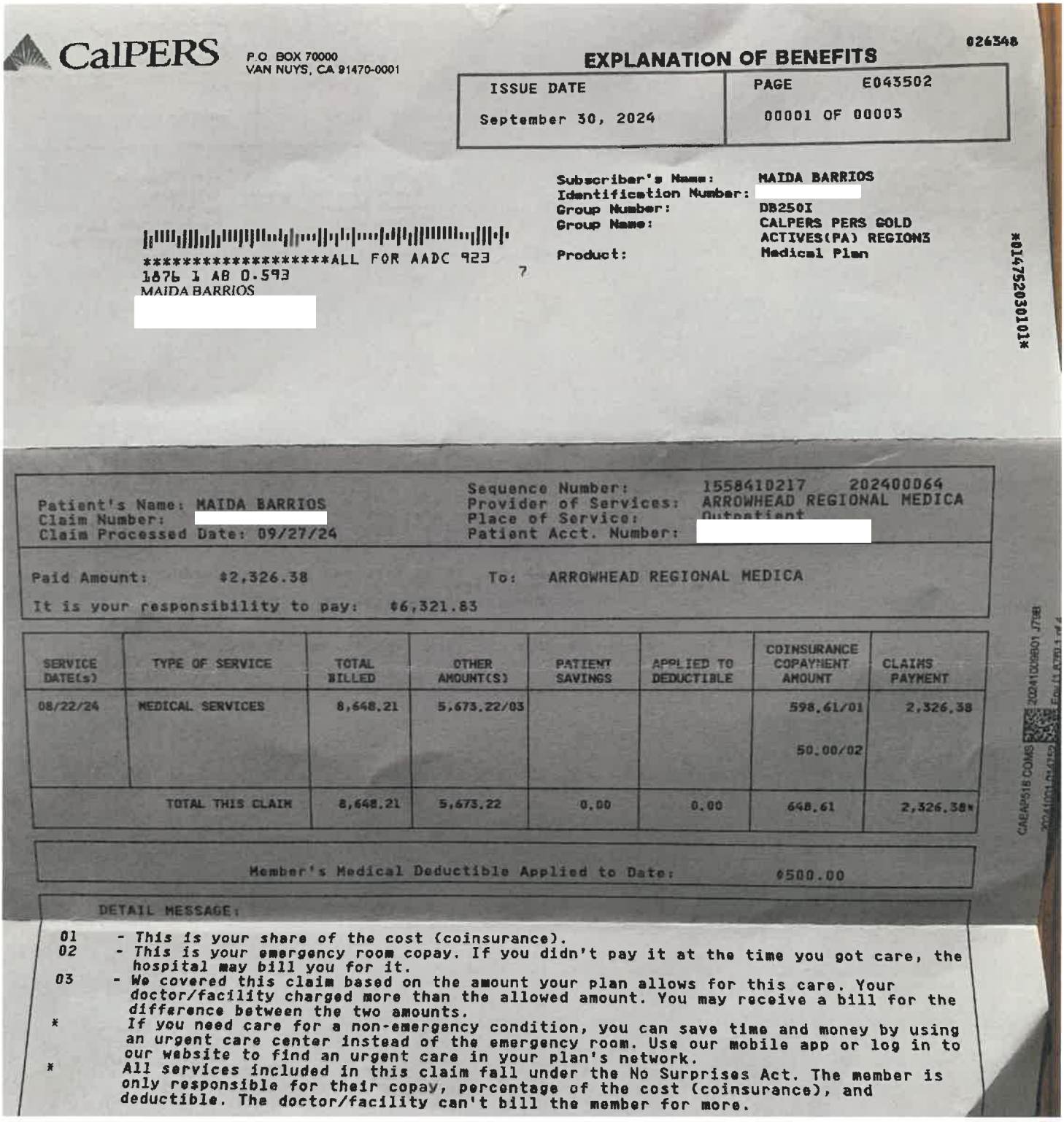
Paid Amount: $0.00

It is your responsibility to pay: $204.61 It is not your responsibility to pay: $582.39

Thank you for using a Network Participating Provider.

SERVICE DATE(s)	TYPE OF SERVICE	TOTAL BILLED	OTHER AMOUNT(S)	PATIENT SAVINGS	APPLIED TO DEDUCTIBLE	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
08/22/24	Radiology-Extremity	50.00		31.82/01	18.18/02		0.00
08/22/24	CT Scan-Head/Neck	124.00		88.48/01	35.52/02		0.00
08/22/24	CT Scan-Head/Neck	124.00		88.48/01	35.52/02		0.00
08/22/24	Radiology-Spine	31.00		19.20/01	11.80/02		0.00
08/22/24	Radiology-Spine	31.00		19.20/01	11.80/02		0.00
08/22/24	CT Scan-Spine	168.00		116.92/01	51.08/02		0.00
08/22/24	CT Scan-Spine	168.00		168.00/03			0.00
08/27/24	Radiology-Extremity	30.00		15.65/01	14.35/02		0.00
08/27/24	Radiology-Extremity	30.00		15.65/01	14.35/02		0.00

CAEAP518 COMS 20240917B01 J39C
20240909 013871 Env [9,841] 1 of 5



CalPERS

P.O. BOX 70000
VAN NUYS, CA 91470-0001

026348

EXPLANATION OF BENEFITS

ISSUE DATE	PAGE
September 30, 2024	00001 OF 00003

Subscriber's Name: MAIDA BARRIOS
Identification Number: [redacted]
Group Number: DB250I
Group Name: CALPERS PERS GOLD ACTIVES(PA) REGION3
Product: Medical Plan

0147520301

**********ALL FOR AADC 923
1876 1 AB 0.593
MAIDA BARRIOS
[redacted]

Patient's Name: MAIDA BARRIOS
Claim Number: [redacted]
Claim Processed Date: 09/27/24

Sequence Number: 1558410217 202400064
Provider of Services: ARROWHEAD REGIONAL MEDICA
Place of Service: Outpatient
Patient Acct. Number: [redacted]

Paid Amount: $2,326.38 To: ARROWHEAD REGIONAL MEDICA

It is your responsibility to pay: $6,321.83

SERVICE DATE(s)	TYPE OF SERVICE	TOTAL BILLED	OTHER AMOUNT(S)	PATIENT SAVINGS	APPLIED TO DEDUCTIBLE	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
08/22/24	MEDICAL SERVICES	8,648.21	5,673.22/03			598.61/01 50.00/02	2,326.38
	TOTAL THIS CLAIM	8,648.21	5,673.22	0.00	0.00	648.61	2,326.38*

Member's Medical Deductible Applied to Date: $500.00

DETAIL MESSAGE:

01 - This is your share of the cost (coinsurance).
02 - This is your emergency room copay. If you didn't pay it at the time you got care, the hospital may bill you for it.
03 - We covered this claim based on the amount your plan allows for this care. Your doctor/facility charged more than the allowed amount. You may receive a bill for the difference between the two amounts.
* If you need care for a non-emergency condition, you can save time and money by using an urgent care center instead of the emergency room. Use our mobile app or log in to our website to find an urgent care in your plan's network.
* All services included in this claim fall under the No Surprises Act. The member is only responsible for their copay, percentage of the cost (coinsurance), and deductible. The doctor/facility can't bill the member for more.

CAEAP518 COMB 20241009801 J7981

Sent from Yahoo Mail for iPhone

On Monday, October 7, 2024, 9:57 PM, La Preciosa <lapreciosa213k@yahoo.com> wrote:

Claim Number: *CAPA-02410559*
Adjuster Name: *Andrew Ortega*

REPORT OF ACCIDENT

Your name Maida Barrios I was a (**please check all that apply**) ☒ driver ☐ passenger
☐ witness ☐ vehicle owner ☐ property owner ☐ other (describe) _____
Accident location include intersecting street(s), city and state Foothill Blvd Rialto CA
Date and **time** of Accident August 22, 2024 7:20am

Accident Location including interesting street(s): **city** and state
Foothill Blvd / Acacia Ave Rialto CA
Weather conditions (**check one**) ☐ Raining ☐ Wet ☐ Dry ☐ Foggy ☐ Snowy ☒ Other: Sunrise
Did the police come to the scene? ☒ Yes ☐ No Report written? ☒ Yes ☐ No Report#: # 221 24-99849
How many vehicles were involved? 2
Were any buildings/property damaged (excluding vehicles)? no

VEHICLE A
Driver Maida Barrios Date of Birth [redacted]
Telephone Number [redacted] Divers License No. [redacted]
Address [redacted]
City, state & zip code Rialto CA 92376
Year 2022 Make Toyota Model Camry License Plate No. [redacted]
Owner of vehicle Maida Barrios
Vehicle towed? ☐ Yes ☒ No Location of damage rear quarter Panel
How many passengers? me (Please list name(s) at the bottom of this page.)
Were any car seats in the vehicle at the time of the loss? no Were any car seats occupied? no
If not occupied, were any car seats damaged? no
Is everyone okay? ☐ Yes ☒ No If not, please explain really hurt my left neck, my left arm, left leg and my back.

VEHICLE B
Driver Rialto Police Department Date of Birth _____
Telephone Number ( ) _____ Divers License No. _____
Address _____
City, state & zip code No info given
Year ____ Make _____ Model _____ License Plate No. _____
Owner of vehicle _____
Vehicle towed? ☐ Yes ☐ No Location of damage Police Report not ready
How many passengers? _____ (Please list name(s) at the bottom of this page.)
Were any car seats in the vehicle at the time of the loss? _____ Were any car seats occupied? _____
If not occupied, were any car seats damaged? _____
Is everyone okay? ☐ Yes ☐ No If not, please explain _____

(If more vehicles were involved, please attach an additional sheet)

On Tuesday, October 1, 2024, 3:27 PM, MyClaim+CAPA-02410559@MercuryInsurance.com <MyClaim+CAPA-02410559@MercuryInsurance.com> wrote:

Your Claim Information

CLAIM NUMBER: CAPA-02410559 / Mercury Insurance Company

Please fill out and send back to me.

Best regards,

Andrew Ortega
Claims Specialist
888-263-7287 X27758

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. (CA Insurance Code § 1871.2(a).)

[redacted]

SIGNATURE

10-7-2024

DATE

CITY OF RIALTO
2024 OCT 23 PM 12:25
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Attached.

Please list any/all passengers and include addresses & telephone numbers

Maida Barrios [redacted] (Text Only)

Please describe how the accident happened. If possible, draw a diagram at the bottom of this page to help with your description I stop my car I blinking for the left. There one lane by the cars. The police were stop & She was texting her phone. I look right & left by the car were stop. I ready drive make a left and the police was [redacted] to go drive use text her phone. text the police didn't see me I drive make a left turn The police saw I. I drive. She [redacted] brake gas to go. She hit hard my car. She said "Sun in her eyes no see good".

How many impacts did you feel, see or hear? one

Who do you feel is at fault and why? Or, what did you think caused this accident? The police using her phone, texting and sun in her eyes

What was the purpose of your trip? [redacted] going to work

Did you have on a Transportation Network application such as Uber or Lyft? no

Were you completing a task or running an errand for your employer? No

Were you wearing a seatbelt? ☒ Yes ☐ No Were the passengers in your vehicle wearing seatbelts? _____

Witnesses? ☐ Yes ☒ No If yes, please provide us with their names, addresses and telephone numbers _____

Are you related to or acquainted with anyone involved in the accident? ☐ Yes ☒ No

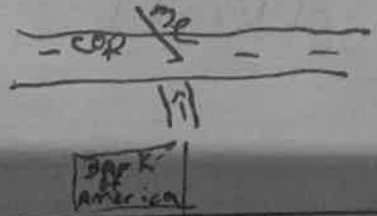
If yes, whom? _____

Where was the other vehicle when you first saw it? No

Where was the other vehicle when you entered the intersection? Stopped on her phone

Why did you make your left hand turn when you did? It was clear to go

Where in the intersection where your vehicles when they collided?



DIAGRAM

0001727 00488 02

MERCURY INSURANCE

P.O. Box 10730 Santa Ana, California 92711-0730

FIRST-CLASS MAIL
PRESORTED
U.S.POSTAGE PAID
ANAHEIM, CA
PERMIT NO. 4656

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Thank You!
We Appreciate Your Business!

ITCLAP1 92376