

Unofficial 20. Document

State Farm Claims
400 E Rio Salado Pkwy
Tempe, AZ 85281

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Notice and Claim of Automobile Insurance Medical Payment Coverage Lien A.R.S. §20-259.01 J

Date Lien Prepared: November 19, 2025

County: Maricopa State: Arizona

Pursuant to A.R.S §20.259.01(J), State Farm Insurance Companies® ("State Farm®") asserts a lien against any claim of liability or indemnity of the insured identified below, arising out of a motor vehicle accident, which occurred on August 29, 2025 within Maricopa County, Arizona. The lien is for all amounts in excess of five thousand dollars (\$5,000.00) paid by State Farm under applicable medical payment coverages.

Injured Party's Information: Name, Address and ZIP Code as same appears on the records of State Farm:

Claim Number: 03-89R3-13S

Carlos Rangel
6835 W Wilshire Dr
Phoenix AZ 85035-1414

Total Medical Payments Paid	\$5,165.00
Less \$5,000.00	(-) \$5,000.00
Amount Claimed by this Lien	\$ <u>165.00</u>

Plus any additional sums

County in which injuries were sustained: Maricopa

To the best of State Farm's knowledge, the names and addresses of all persons, firms, or corporations and the insurance carriers for such persons, firms, or corporations claimed by the above-named insurer, or their legal representative to be liable for damages are:

Individuals or Entities

Carlos Rangel c/o Amara & Assoc
2 N Central Ave Ste 1936
Phoenix, AZ 85004-2322

Roberto C Cruz Reveles
23798 N Wilderness Way
Florence AZ 85132-5135

Insurers for Individuals or Entities

Liberty Mutual Claim 060026246
PO Box 5014
Scranton PA 18505-5014

The above-named claimants (injured party), in accordance with Arizona revised statutes do hereby claim a lien upon any and all causes of action, suits, claims, counterclaims, or demands accruing to the above-named injured party or to the legal representative of such injured party, as a result of injuries giving rise to such causes of action and which made necessary his/her treatment, for the customary charges for medical payment coverage of the above named injured party in the sum hereinabove claimed to be due.

) § Verification of Authorized Agent**Karen Lovato**Digitally signed by Karen Lovato
Date: 2025.11.23 17:40:10 -07'00'

_____, agent of State Farm Insurance, being first duly sworn, upon oath deposes and says that he/she is an agent of State Farm, above subscribed and that he/she is authorized to act on behalf of said insurance company.

Karen LovatoDigitally signed by Karen Lovato
Date: 2025.11.23 17:40:29
-07'00'_____
Signature of Agent of State Farm

Telephone Number: (844) 292-8615 Ext. 516

Affidavit of Proof of Service

_____, Agent, being duly sworn, upon oath deposes and says that he/she is an authorized agent of State Farm Insurance named in the preceding notice and claim of insurance medical payment coverage lien, that he/she is authorized to act on behalf of said insurance company, that he/she did within five (5) days after the recording of said notice and claim of insurance medical payment coverage lien and on the _____ day of

_____, _____, did send by certified mail, postage prepaid, copies thereof to each person, firm, or corporation, and the insurance carrier of such persons, firm or corporation claimed in the said notice and claim of insurance medical payment coverage lien to be liable for damages at the addresses given in the preceding statement.

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Signature of Agent of State Farm