



Patient Name Account # Statement Date

Sophia Jongsma

01034421

Statement Date

12/25/2025

AMOUNT DUE

\$287.51

We have billed your insurance and the remaining balance is your responsibility. One or more of your charges are in **FINAL NOTICE**. Please see next step below.

Make
Payment in
Full

To Make a Payment

Pay your bill online at baycare.org/pay-my-bill or call us at (800) 940-5151 (Available 24/7)

PAYMENT
PLANS

If you are unable to pay your amount due in full and would like to establish a monthly payment plan, please contact us at (855) 533-5200 or log onto www.MedMaxFinance.com.

FINANCIAL
ASSISTANCE

If you are unable to pay, you may be eligible for financial assistance. Please call 727-394-6401.



PAY
ONLINE
AT

personapay.com/bchc



BayCare

Detach and return with your payment. Please make checks payable to BayCare HomeCare. Any changes to Address and/or Insurance should be noted on the back of the coupon.



BAYCARE HOMECARE
PO BOX 741704
ATLANTA GA 30374-1704

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW		
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> DISCOVER <input type="checkbox"/> VISA <input type="checkbox"/> AMEX
CARD NUMBER		EXP. DATE
PRINT NAME		MUST INCLUDE SECURITY CODE FROM CREDIT CARD (CVV)
SIGNATURE		AMOUNT
STATEMENT DATE	AMOUNT DUE	PAYMENT DUE DATE
12/25/2025	\$287.51	Upon Receipt

Pay online at <http://www.personapay.com/bchc>



SOPHIA JONGSMA
851 BRIGHTWATERS BLVD NE
ST PETERSBURG FL 33704-3719

BAYCARE HOMECARE
PO BOX 741704
ATLANTA GA 30374-1704

0000000010344210000287515

141717-BAY-BA13-687

IF WE DO NOT HAVE YOUR INFORMATION, OR IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE...

PATIENT INFORMATION

Your Name (Last, First, Middle Initial)	Date of Birth	
Address		
City	State	Zip
Telephone ()		
Social Security #		
Employer's Name	Telephone ()	
Employer's Address		
City	State	Zip
Please Indicate if Applicable:		Date of Injury
<input type="checkbox"/> AUTO ACCIDENT		
<input type="checkbox"/> WORKER'S COMPENSATION		

INSURANCE INFORMATION

Your PRIMARY Insurance Company's Name		
Primary Insurance Company's Address		
City	State	Zip
Policyholder Name	Date of Birth	Sex
Policyholder's ID Number		Group Plan Number
Your SECONDARY Insurance Company's Name		
Secondary Insurance Company's Address		
City	State	Zip
Policyholder Name	Date of Birth	Sex
Policyholder's ID Number		Group Plan Number



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Sophia Jongsma	01034421	12/25/2025
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AMOUNT DUE

\$287.51

STATEMENT OF SERVICES (AS OF December 25, 2025)

Any Balance with FINAL NOTICE not paid in 30 days may be forwarded to a collection agency

DATE	HCPC CODE	QTY	DESCRIPTION	STATUS	BALANCE
9/10/2025	E0465	1	VENTILATOR	Final Notice	\$287.51

PAY ONLINE!  <http://www.personapay.com/bchc>

BALANCE DUE
UPON RECEIPT

\$287.51

CONTACT US FOR QUESTIONS ABOUT YOUR BILL

Call 727-394-6401.
Monday thru Friday 8:00 am to 4:00pm