BayCare HomeCare

Patient Name	Account #	Statement Date	AMOUNT DUE
Sophia Jongsma	01034421	12/25/2025	$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.

PAY ONLINE AT

personapay.com/bchc

BayCare

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.

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

BAYCARE HOMECARE
PO BOX 741704
ATLANTA GA 30374-1704

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW		
☐ ☐ DISCOVER ☐ VISA ☐ AMEX		
CARD NUMBER	EXP. DATE	MUST INCLUDE SECURITY CODE FROM CREDIT CARD (CVV)
PRINT NAME		
SIGNATURE	AMOUNT	

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

STATEMENT DATE	AMOUNT DUE	PAYMENT DUE DATE
12/25/2025	$287.51	Upon Receipt

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

BAYCARE HOMECARE
PO BOX 741704
ATLANTA GA 30374-1704

00000000103442100000287515

141717-BAY-BAI3-687

0069 007520

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:
☐ AUTO ACCIDENT
☐ WORKER'S COMPENSATION

Date of Injury

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