BayCare HomeCare

Patient Name	Account #	Statement Date	AMOUNT DUE
Sophia Jongsma	01034421	2/12/2026	$1,781.25

Dear Sophia Jongsma,

Thank you for choosing BayCare HomeCare. The services on the enclosed billing statement have been billed to and processed by your insurance(s) on file. The amount due is now your responsibility. Payment options for the amount due are listed below.

PAY ONLINE AT personapay.com/bchc

PAYMENT OPTIONS

- Pay online at http://www.personapay.com/bchc (Available 24/7)
- Mobile App: BayCare Health System
- Please call (800) 940-5151.
- Mail in the payment to us using the coupon below.

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
2/12/2026	$1,781.25	Upon Receipt

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

BAYCARE HOMECARE
PO BOX 741704
ATLANTA GA 30374-1704

00000000103442100001781250

141717-BAY-BAI1H-11

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

☐ AUTO ACCIDENT

☐ 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

BayCare HomeCare

Patient Name	Account #	Statement Date	AMOUNT DUE
Sophia Jongsma	01034421	2/12/2026	$1,781.25

STATEMENT OF SERVICES

(AS OF February 12, 2026)

DATE	HCPC CODE	QTY	DESCRIPTION	BALANCE
1/10/2026	E0465	1	VENTILATOR	$1,781.25

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

BALANCE DUE UPON RECEIPT	$1,781.25

CONTACT US FOR QUESTIONS ABOUT YOUR BILL

☎ Call 727-394-6401.

Monday thru Friday 8:00 am to 4:00pm