

**TOTAL PAYMENT DUE****\$000.00**

GUARANTOR NAME	MEDICAL RECORD #	GUARANTOR ID	STATEMENT DATE	DUE DATE
Paula Patient	123456	2345678	00/00/00	00/00/00

Thank you for choosing Baylor Scott & White Health for your care. Your insurance has processed your claim for this account. Our records indicate the remaining balance is your responsibility. Listed below are the payment options that we offer.

**PAYMENT  
OPTIONS**

You may pay your bill in full with a check, credit card, or debit card:

- Pay online at [www.sw.org/mychart](http://www.sw.org/mychart)
- Mail the payment using the slip below
- Pay-by-Phone 1-800-994-0371

**PAYMENT  
PLAN**

If you are unable to pay your bill in full and would like to set up an interest-free payment arrangement or have new account balances that you would like to combine with your existing payment plan agreement, please call Customer Service at 1-800-994-0371.

**FINANCIAL  
ASSISTANCE**

If you are unable to pay your balance, you may be eligible for financial assistance. Please call Customer Service at 1-800-994-0371. Please visit our website: <http://www.sw.org/Patient-Tools/Financial-Assistance>

Pay your bill, access  
your account detail,  
review your medical  
record & more with  
Baylor Scott & White  
Health's MyChart

Go to:  
[www.sw.org/mychart](http://www.sw.org/mychart)

Your MyChart Code: **12**  
ABCD-EFGH

**QUESTIONS?**

Call Customer Service at 1-800-994-0371  
Monday through Friday  
8:00AM - 11:30AM, 12:30PM - 5:00PM

[detailed summary](#)

Detach this slip and return with your payment.



Dept. 123477  
PO Box 1259  
Oaks, PA 19456  
RETURN SERVICE REQUESTED



Pay online at [www.sw.org/mychart](http://www.sw.org/mychart)

PAULA PATIENT  
123 MAIN STREET  
ANYTOWN, PA 12345-1234



IF PAYING BY CREDIT/DEBIT CARD		
<input type="checkbox"/> VISA	<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> AMERICAN EXPRESS
<input type="checkbox"/> DISCOVER		
CARD NUMBER	SECURITY CODE	EXP DATE
SIGNATURE		
STATEMENT DATE	GUARANTOR ID	DUE DATE
00/00/00	2345678	00/00/00
AMOUNT DUE	SHOW AMOUNT PAID HERE	
\$000.00		

PLEASE MAKE CHECKS PAYABLE TO:  
BAYLOR SCOTT & WHITE HEALTH

Baylor Scott & White Health  
P.O. Box 674350  
Dallas, TX 75267-4350



- Total Payment Due:** Amount you are responsible for as of the statement date. This amount takes into consideration payments received by you and/or your insurance company and any adjustments or discounts BSWH has applied to your account.
- Guarantor Name:** Name of person BSWH has on file that is responsible for payment.
- Medical Record #:** BSWH assigns each patient a unique permanent medical record number (MRN). The MRN is a critical link between a patient and the patient's medical records.
- Guarantor ID:** A unique number assigned to the person responsible for payment for services provided by BSWH.
- Statement Date:** Date your billing statement was created.
- Due Date:** Date your payment must be received by BSWH.
- Statement Message Field:** Contains important information regarding your bill. Please note BSWH will send a minimum of four post-discharge billing statements over a 120 day period. If the account has not been resolved or a payment plan has not been established, your account may be placed with a collection agency.
- Payment Options:** Pay online, by phone, by mail, or use your smartphone's camera and Quick Response (QR) code reader application to scan and launch BSWH's payment web page.

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BAYLOR SCOTT & WHITE HEALTH

Baylor Scott & White Health  
P.O. Box 674350  
Dallas, TX 75267-4350



- Payment Plan:** BSWH offers extended, interest-free payment plans and options to help minimize the impact of your healthcare bill.
- Financial Assistance:** BSWH representatives can discuss financial assistance programs that may be available to you.
- MyChart:** MyChart is a secure electronic way to manage your appointments, review and pay your bill, view your medications and test results, and communicate with your BSWH health care team. It is a convenient, confidential online connection tool.
- MyChart Code:** Enter your MyChart code exactly as it appears on your statement (use all capital letters and include the dashes). Upon activation this code will expire and may be safely discarded.
- Customer Service:** Our team is available to assist you if you have any questions about your billing statement or financial assistance.
- Guarantor Mailing Address:** If this is incorrect, please provide the correct guarantor mailing address and return the slip to BSWH.
- Pay by Credit/Debit card:** If paying by credit/debit card, all data fields in this section should be completed and mailed to the address in Section #17.
- Pay by Check:** If paying by check, please make your check payable to Baylor Scott & White Health and include your account number on the check.
- Payable Mailing Address:** Please be sure to detach slip and mail your payment to this address.



## TOTAL PAYMENT DUE

\$000.00

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### ACCOUNT SUMMARY

Amount Paid By Your Insurance	\$000.00	18
Amount Paid By You	\$0.00	19
<b>Current Account Balance</b>	<b>\$000.00</b>	20

### PRIMARY INSURANCE

Insurance Name	ANY INSURANCE	21
Group/Plan	XXXXX	
ID Number	XXXXXXXXXX	

### SECONDARY INSURANCE

Insurance Name	ANY INSURANCE	
Group/Plan		
ID Number	XXXX	

Patient: Paula Patient		22	26	27	28	29	30	31
FACILITY/ PROVIDER	SERVICE DATE	SERVICE DESCRIPTION	ACCOUNT NUMBER	CHARGES	ADJUSTMENT/ DISCOUNTS	INSURANCE PAYMENTS	PATIENT PAYMENTS	BALANCE DUE
Dr Joe Sample, MD	00/00/00	PR OFFICE OUTPATIENT	123456789	0.00				
		SPECIAL EYE EXAM, SUBSEQUENT		0.00				
		SPECIAL EYE EXAM, SUBSEQUENT		0.00				
		COMPUTERIZED OPHTHALMIC IMAGING		0.00				
		RETINA						
		<b>TOTAL CHARGES</b>		<b>0.00</b>				
		INSURANCE PAYMENT - MEDICARE			-0.00	-0.00		
		Total Discounts & Adjustments						
		<b>CURRENT BALANCE DUE</b>		<b>0.00</b>	<b>-0.00</b>	<b>-0.00</b>	<b>0.00</b>	<b>0.00</b>

The amounts are currently due. Please remit payment as soon as possible.

18. **Amount Paid By Your Insurance:** Total insurance payments received at time of statement.
19. **Amount Paid By You:** Total payments received from the person responsible for payment at time of statement.
20. **Current Account Balance:** Current balance due at the time of statement.
21. **Primary and Secondary Insurance:** Most current insurance information on file with BSWH at time of statement. If this is not correct, please contact us at **1-800-994-0371**.
22. **Patient:** Name of the patient who received services.
23. **Facility/Provider:** The name of the facility and/or provider that provided the services.
24. **Service Date:** The date(s) services were rendered.
25. **Service Description:** Description of services rendered by the provider and/or the hospital.
  - a) This is the charge for your provider and office visit.
  - b) This is the charge for facility/technical services provided at the hospital/clinic.
26. **Account Number:** Your account number is used for billing purposes for that specific service date and type of service. Please note this is not your medical record number.
27. **Charges:** Charges for services provided.
28. **Adjustments/Discounts:** Reflects total adjustments and discounts that have been applied.
29. **Insurance Payments:** The amount received from the patient's insurance company for services provided.
30. **Patient Payments:** The amount received from the person responsible for payment.
31. **Balance Due:** The amount outstanding for the account number listed as of the statement date.