



TOTAL PAYMENT DUE ¹

\$000.00

GUARANTOR NAME ²	MEDICAL RECORD # ³	GUARANTOR ID ⁴	STATEMENT DATE ⁵	DUE DATE ⁶
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. ⁷

PAYMENT OPTIONS

You may pay your bill in full with a check, credit card, or debit card: ⁸

- Pay online at 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. ⁹

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> ¹⁰

Pay your bill, access your account detail, review your medical record & more with Baylor Scott & White Health's MyChart ¹¹

Go to:
www.sw.org/mychart

Your MyChart Code: ¹²
ABCD-EFGH

QUESTIONS? ¹³ Call Customer Service at 1-800-994-0371
Monday through Friday
8:00AM - 11:30AM, 12:30PM - 5:00PM

[detailed summary](#) >

106072_C_CTX

Detach this slip and return with your payment.

Baylor Scott & White Health
Dept. 123477
PO Box 1259
Oaks, PA 19456
RETURN SERVICE REQUESTED



Pay online at www.sw.org/mychart

¹⁴ PAULA PATIENT
123 MAIN STREET
ANYTOWN, PA 12345-1234



IF PAYING BY CREDIT/DEBIT CARD ¹⁵

VISA MASTERCARD AMERICAN EXPRESS DISCOVER

CARD NUMBER	SECURITY CODE	EXP DATE
SIGNATURE		
STATEMENT DATE	GUARANTOR ID	DUE DATE
00/00/00	2345678	00/00/00
A MOUNT DUE	SHOW AMOUNT PAID HERE	
\$000.00		

¹⁶ PLEASE MAKE CHECKS PAYABLE TO:
BAYLOR SCOTT & WHITE HEALTH

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

¹⁷



- 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 ¹⁷
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.



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\$000.00

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

ACCOUNT SUMMARY	
Amount Paid By Your Insurance	\$000.00 ¹⁸
Amount Paid By You	\$0.00 ¹⁹
Current Account Balance	\$000.00 ²⁰

PRIMARY INSURANCE ²¹	
Insurance Name	ANY INSURANCE
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 ²³	SERVICE DATE ²⁴	SERVICE DESCRIPTION	ACCOUNT NUMBER	CHARGES	ADJUSTMENT/ DISCOUNTS	INSURANCE PAYMENTS	PATIENT PAYMENTS	BALANCE DUE
Dr Joe Sample, MD	00/00/00	PR OFFICE OUTPATIENT ^{25 a}	123456789	0.00				
		SPECIAL EYE EXAM, SUBSEQUENT ^{25 b}		0.00				
		SPECIAL EYE EXAM, SUBSEQUENT		0.00				
		COMPUTERIZED OPHTHALMIC IMAGING RETINA		0.00				
		TOTAL CHARGES		0.00				
		INSURANCE PAYMENT - MEDICARE			-0.00	-0.00		
		Total Discounts & Adjustments						
		CURRENT BALANCE DUE		0.00	-0.00	-0.00	0.00	0.00

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.