

4. Current Practice Location (Continued)**C. Medicare Payment "Pay To" Address Information** ☐ **Change** **Effective Date:** _____

Furnish the address where payments should be sent for services rendered at the practice location in Section 4B.

"Pay To" Address (Organization or Individual Name)

"Pay To" Address Line 1 (Street Name and Number)

"Pay To" Address Line 2 (Suite, Room, etc.)

City

State

ZIP Code + 4

Check here ☐ **and submit a completed Form HCFA-588 with this application if you would like to have your payments electronically transferred to your bank account.****D. Location of Patients' Medical Records** ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:** _____**1.** Check here ☐ if **all** of your patients' medical records are stored in the practice location(s) shown in Section 4B, and skip this section.**2.** If **any** of your patients' medical records are stored in a location other than the practice location(s) shown in Section 4B, complete this section for each additional storage location.

Name of Storage Facility/Location

Street Address Line 1

Street Address Line 2

City

State

ZIP Code + 4

E. Comments

Explain any unique or unusual circumstances concerning your practice location(s) or the method by which you render health care services (e.g., you only render services in patients' homes (house calls only)).