GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Health Care Finance IRS Form 1095-B Correction Request

****** DO NOT SUBMIT THIS FORM TO THE IRS*********
SUBMIT THIS FORM AND ALL REQUIRED DOCUMENTATION TO ECONOMIC SECURITY ADMINISTRATION (ESA)

Name of Responsible Individual: _____

Address: _____

Phone number: _____ E-mail (optional): _____

How to Submit the Form 1095 -B Correction Request		
By Email	By Mail	By Phone
Email your request to: DHCF.1095B@dc.gov Subject line: 1095B Correction Request	Department of Human Services Economic Security Administration Form 1095-B Processing Unit 645 H Street NE, 4th Floor Washington, DC 20077 -0555	DCAS Call Center 1-202-727-5355 (for TTY, call 711)

How to complete the Correction Request Form:
Below is a blank copy of the Form 1095-B.

1. Enter the correct information in the boxes where you think we made a mistake. **Do not fill in boxes that were correct on your Form 1095-B.**
2. Check the Documentation section for needed documentation.
3. Sign and date the request form.
4. Submit the Correction Request Form by email, postal mail, or drop off at a Service Center near you with the required document. The Documentation Table listing the acceptable documents is below.

Part I **Responsible Individual**

1 Name of responsible individual		2 Social security number (SSN)	3 Date of birth (If SSN is not available)
4 Street address (including apartment no.)	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
8 Enter letter identifying Origin of the Policy (see instructions for codes): . . . . . ▶		9 Small Business Health Options Program (SHOP) Marketplace identifier, if applicable	

Part II **Employer Sponsored Coverage** (see instructions)

10 Employer name			11 Employer identification number (EIN)
12 Street address (including room or suite no.)	13 City or town	14 State or province	15 Country and ZIP or foreign postal code

Part III **Issuer or Other Coverage Provider** (see instructions)

16 Name		17 Employer identification number (EIN)	18 Contact telephone number
19 Street address (including room or suite no.)	20 City or town	21 State or province	22 Country and ZIP or foreign postal code

Part IV **Covered Individuals** (Enter the information for each covered individual(s).)

	(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of coverage											
					Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23																
24																
25																
26																

Documentation Table:

To make sure that we have the correct and complete information to process your Correction request, we need you to provide documentation to verify your request. Below is the list of acceptable documentation based on the type of correction.

Correction Request Type	Acceptable Documentation Needed
Name	Copy of Birth certificate, Court Document (for name changed), or other legal document that shows the complete name
Social Security Number	Copy of Social Security card, prior tax forms, or any other legal document showing the correct number
Date of Birth	Copy of Birth Certificate or any other legal document showing the correct date of birth
Month of Coverage	Copy of Notices that shows your covered months (if available).

NOTE: You do not need to complete a Correction Request for incorrect address, contact the Economic Security Administration (ESA) directly to correct your address.

Certification:

By signing below, you attest or agree that you understand the following:

- **I understand** that the eligibility information contained in the Form 1095-B comes from the information I submitted when I applied for Medicaid or CHIP.
- **I attest** that I am the Responsible Individual receiving the Form 1095-B for my tax household and I am authorized to request the changes indicated above.
- **I attest** that the corrections indicated above are requested based on a valid, true, and accurate records of my tax household.
- **I understand** that the Department of Health Care Finance does not administer the tax law, exemptions, or penalties associated with the tax law.
- **I understand** that Department of Health Care Finance cannot assist me to prepare my tax return or answer questions on how to complete tax forms.

Signature: _____ Date: _____