DC HEALTH LINK
Get the facts. Get covered.

IRS Form 1095-A Correction Request

Marketplace-assigned policy number (Box 2 of Form 1095-A) (REQUIRED):

Taxpayer name

Address

Phone number	**12** E-mail (optional)
( ) -	

Tax year

The section below is a blank copy of Form 1095-A. Please enter the correct information in the boxes where you think we made a mistake. You do not need to fill in boxes that were correct on your Form 1095-A. Please be sure to check the table on page 4 to find out what documents you will need to submit along with your correction request.

Part I Recipient Information

1 Marketplace identifier ***** OFFICIAL USE ONLY ******	**2** Marketplace-assigned policy number ***** OFFICIAL USE ONLY ******	**3** Policy issuer's name ***** OFFICIAL USE ONLY ******

4 Recipient's name	**5** Recipient's SSN - -	**6** Recipient's date of birth Only Complete if SSN not Present / /
7 Recipient's spouse's name Only Complete if receiving Advance Premium Tax Credit (APTC)	**8** Recipient's spouse's SSN Only if receiving APTC - -	**9** Recipient's spouse's date of birth Only Complete if SSN not Present / /

10 Policy start date / /	**11** Policy termination date / /	**12** Street address (including apartment no.)
13 City or town	**14** State or province	**15** Country and ZIP or foreign postal code

THIS FORM WILL BE REJECTED WITHOUT SIGNATURE ON PAGE 3

Part II Covered Individuals

A. Covered Individual Name	B. Covered Individual SSN	C. Covered Individual Date of Birth (Only Complete if SSN not Present)	D. Coverage Start Date	E. Coverage Termination Date
16	- -	/ /	/ /	/ /
17	- -	/ /	/ /	/ /
18	- -	/ /	/ /	/ /
19	- -	/ /	/ /	/ /
20	- -	/ /	/ /	/ /

Part III Coverage Information

Month	A. Monthly enrollment premiums	B. Monthly second lowest cost silver plan (SLCSP) premium	C. Monthly advance payment of premium tax credit (APTC)
21 January	$	$	$
22 February	$	$	$
23 March	$	$	$
24 April	$	$	$
25 May	$	$	$
26 June	$	$	$
27 July	$	$	$
28 August	$	$	$
29 September	$	$	$
30 October	$	$	$
31 November	$	$	$
32 December	$	$	$
33 Annual Totals	$	$	$

THIS FORM WILL BE REJECTED WITHOUT SIGNATURE ON PAGE 3

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

- **I understand** that the contract for insurance is between the covered individual and the insurance company, and the information contained in the Form 1095-A comes from information provided by the insurance company based on a customer's coverage history. Coverage is not provided by DC Health Link, and DC Health Link plays no role in the collection of premiums or reconciliation of payment.
- **I attest** that I am the federal taxpayer responsible for receiving the IRS Form 1095-A for my tax household, and am authorized to request the changes indicated above.
- **I attest** that the corrections indicated above are requested based on thorough research into my financial records, and represent a true and accurate record of my enrollment and/or that of others in my tax household.
- **I attest** that I have paid all premium payments due to the health insurance company listed in Box 3 of this form for all months of coverage I obtained from the company in the tax year, after all advance premium tax credits have been deducted.
- **I attest** that I have not had my coverage cancelled or terminated for any months in the tax year for which a premium is listed in Column A of Part III of this form.
- **I understand** that DC Health Link is not responsible for reconciliation of premium tax credits. Reconciliation occurs between the taxpayer and the Internal Revenue Service.
- **I understand** that DC Health Link does not administer the federal individual mandate or federal tax penalties associated with the mandate for 2018 or prior years.
- **I understand** that DC Health Link cannot help me prepare my tax return or answer questions on how to complete tax forms.

Taxpayer signature: _____ **Date:**_____/ /_____

How to Submit Form 1095-A Correction Request

BY EMAIL
info@dchealthlink.com
Subject: Request for 1095-A Correction

BY MAIL
1095-A Processing Unit
1225 Eye St NW, Suite 400
Washington, DC 20005

THIS FORM WILL BE REJECTED WITHOUT SIGNATURE ON PAGE 3

Correction Type	Documentation Needed
Name	Invoice or other document from your insurance company with the correct name.
Social Security Number	A copy of your social security card.
Date of Birth	Official document showing date of birth (such as a passport, driver's license, or birth certificate) AND invoice or other document from your insurance company with the name of the person whose date of birth is being corrected.
Address	No documentation needed.
Policy Start Date or Policy Termination Date	Invoice or other document from your insurance company showing the correct start or end date for your coverage.
Monthly Premium Amount	Invoice or other document from your insurance company showing the correct monthly premium amount. Please read the Notes for Column A before submitting this request, because the premium amount that the IRS requires on Form 1095-A is usually different than the amount you pay each month.
Monthly Premium Amount of Second Lowest Cost Silver Plan (SLCSP)	Please see notes for Column B before submitting this request. If you did not receive an advance premium tax credit, you should get the values needed for this column by using the Second Lowest Cost Silver Plan Calculator. You do not need a corrected Form 1095-A for these values.
Monthly Advance Payment of Premium Tax Credit	Invoice or other document from your insurance company showing the amount of advance premium tax credit (APTC) and the months you received the credit.

THIS FORM WILL BE REJECTED WITHOUT SIGNATURE ON PAGE 3

Part III Column A – Monthly Premium Amount

- The amount in Column A may be different from the amount you paid because it only includes that portion of your premium that went to pay for the Essential Health Benefits (EHBs). All plans sold on DC Health Link include additional benefits beyond EHBs, meaning the cost listed on Form 1095-A will usually be a few dollars lower than the full cost of the premium. Column A also does not include any discount you may have received for the advance premium tax credit.
- If you believe you paid a premium for a month that is left blank in Column A, check to be sure that the payment you made was not for a different month.

Part III Column B – Monthly Premium Amount of Second Lowest Cost Silver Plan (SLCSP)

- This column will be blank if you did not receive an advance premium tax credit during the tax year. If you want to see if you qualify for the premium tax credit on your taxes, you can get the numbers needed to fill in this column by using the Second Lowest Cost Silver Plan Calculator at DC Health Link. You do not need a corrected 1095-A for these numbers.
- Any person who had other health insurance coverage or was eligible for other coverage (like Medicaid or coverage provided by an employer) will have an SLCSP of $0 for all months that other coverage was available.
- The Second Lowest Cost Silver Plan (SLCSP) is based on a person's age on the first day they were enrolled in coverage with premium tax credits during the tax year, not their current age.

Part III Column C – Monthly Advance Payment of Premium Tax Credit

- This is the amount of advance premium tax credit that you received each month as a discount off of your premium. This will have to be reconciled when you file your taxes. If you did not receive this discount on the invoice from your insurance company, you should submit a copy of that invoice to your insurance company and ask for a correction. If you did receive it, and it is not listed here, you should also submit your invoice to your insurance company and ask for a correction.

THIS FORM WILL BE REJECTED WITHOUT SIGNATURE ON PAGE 3