IRS Form 1095-B Desk Reference

The **Responsible Individual** is the person listed in the system (CBMS) as the Head of Household for the Medicaid/CHP+ case.

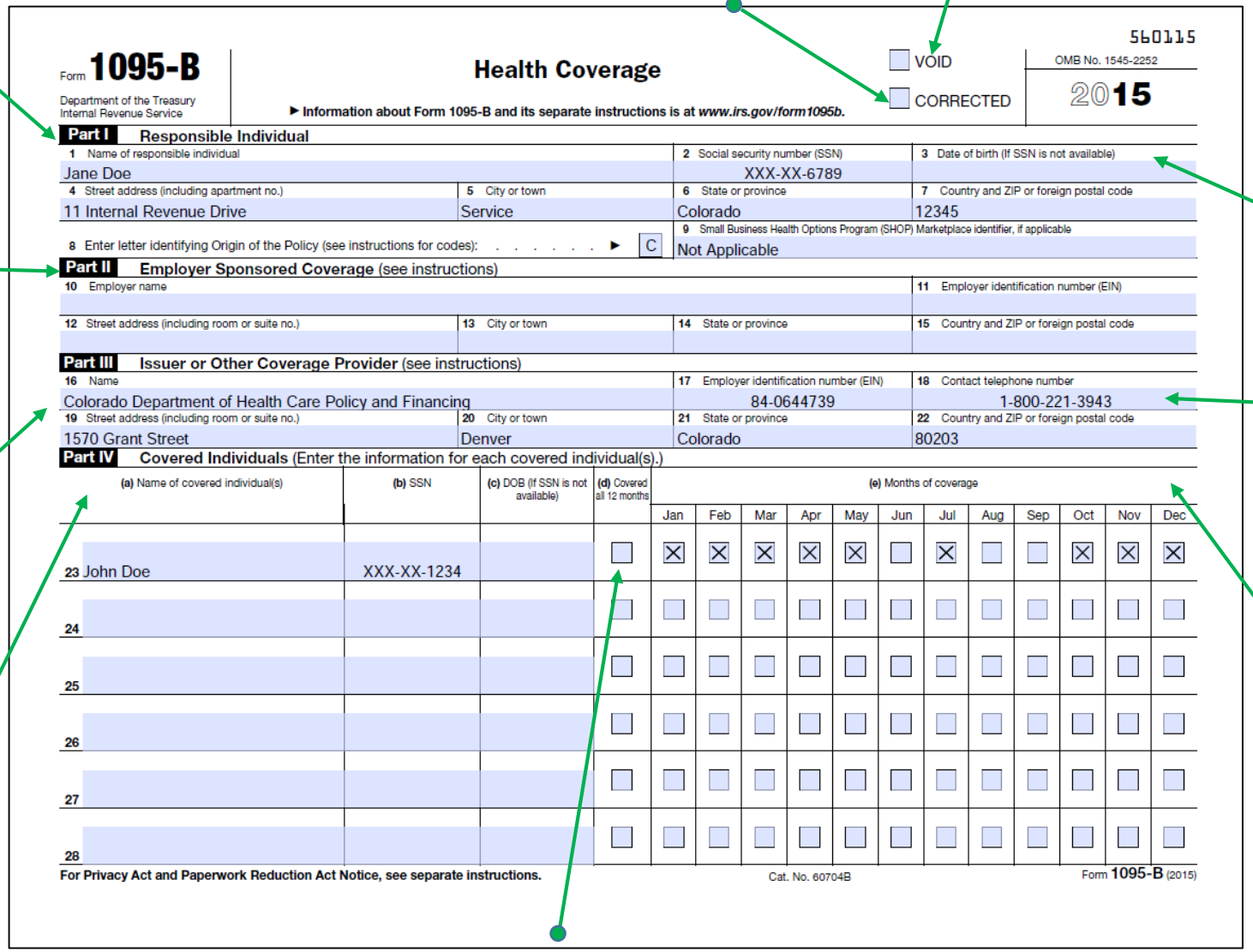
Part II will be left blank on all 1095-B forms sent by the Department.

The Department is the **Issuer** of Medicaid and CHP+ in Colorado.

A **Covered Individual** is a person who had Medicaid or CHP+ for at least one day in 2015.

The **Corrected** box will be marked if the information on the original 1095-B form was changed for any reason.

The **Void** box will never be marked.



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Form **1095-B** — Department of the Treasury, Internal Revenue Service

Health Coverage

► Information about Form 1095-B and its separate instructions is at *www.irs.gov/form1095b.*

☐ VOID ☐ CORRECTED

OMB No. 1545-2252

2015

Part I Responsible Individual

1 Name of responsible individual	2 Social security number (SSN)	3 Date of birth (If SSN is not available)
Jane Doe	XXX-XX-6789	

4 Street address (including apartment no.)	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
11 Internal Revenue Drive	Service	Colorado	12345

8 Enter letter identifying Origin of the Policy (see instructions for codes): . . . . . ► C

9 Small Business Health Options Program (SHOP) Marketplace identifier, if applicable: Not 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
Colorado Department of Health Care Policy and Financing	84-0644739	1-800-221-3943

19 Street address (including room or suite no.)	20 City or town	21 State or province	22 Country and ZIP or foreign postal code
1570 Grant Street	Denver	Colorado	80203

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	John Doe	XXX-XX-1234		☐	☒	☒	☒	☒	☒	☐	☒	☐	☐	☒	☒	☒
24				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60704B Form 1095-B (2015)

Date of birth will be left blank unless there is no Social Security Number (SSN) available.

The **Contact telephone number** is the Medicaid Customer Contact Center.

The box below the **Month of coverage** is marked if the client was enrolled in CHP+ or Medicaid for at least one day in 2015.

Covered all 12 months will be marked if the client had Medicaid or CHP+ for all of 2015.

COLORADO
Department of Health Care Policy & Financing

Visit Eligibility Partner FAQs & Training on Colorado.gov/HCPF, and then go to the IRS Form 1095-B: Health Coverage folder to read more about Form 1095-B.