

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.

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.

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.

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.

Form **1095-B** Health Coverage

Department of the Treasury Internal Revenue Service

560115 OMB No. 1545-2252

2015

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

VOID CORRECTED

Part I Responsible Individual

1 Name of responsible individual: Jane Doe

2 Social security number (SSN): XXX-XX-6789

3 Date of birth (If SSN is not available):

4 Street address (including apartment no.): 11 Internal Revenue Drive

5 City or town: Service

6 State or province: Colorado

7 Country and ZIP or foreign postal code: 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: Colorado Department of Health Care Policy and Financing

17 Employer identification number (EIN): 84-0644739

18 Contact telephone number: 1-800-221-3943

19 Street address (including room or suite no.): 1570 Grant Street

20 City or town: Denver

21 State or province: Colorado

22 Country and ZIP or foreign postal code: 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		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
24			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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