DC HEALTH LINK
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IRS Form 1095-A Correction Request

for corrections to 2014, 2015 and 2016 tax forms

DO NOT SUBMIT THIS FORM TO THE IRS
SUBMIT THIS FORM AND ALL REQUIRED DOCUMENTATION TO DC HEALTH LINK

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

Taxpayer Name: ____

Address: ____

Phone Number: ___________________________ **E-mail (optional):** _____________________________________

How to Submit Form 1095-A Correction Request	
By Email	**By Mail**
DCHL.1095A@dc.gov Subject: Request for 1095-A Correction	1095-A Processing Unit 1225 Eye St NW, Suite 400 Washington, DC 20005

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 tables on pages 3 & 4 to find out what documents you will need to submit along with your signed correction request form.

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 1095-A form 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, after all Advance Premium Tax Credits have been deducted.
- **I attest** that I have not had my coverage canceled or terminated for any months 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; that occurs between the taxpayer and the Internal Revenue Service.
- **I understand** that DC Health Link is does not administer the Individual Mandate, exemptions from the mandate or tax penalties associated with the mandate.
- **I understand** that DC Health Link cannot assist me to prepare my tax return or answer questions on how to complete tax forms.

Taxpayer Signature: ____ Date: __________________________

Notes

Correction Type	Documentation Needed
Name	Invoice or other document from your insurance company with the correct name
Social Security number	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

Correction Type	Documentation Needed
Monthly Enrollment Premiums *also called Monthly Premium Amount)*	Invoice or other document from your insurance company showing the correct monthly premium amount. Please read the notes below for Part III, 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 paid each month.
Monthly Premium Amount of Second Lowest Cost Silver Plan (SLCSP)	**See notes below for Part III, Column B. I**f you did not receive an advanced premium tax credit with your coverage, you should get the values needed for this column by using the Second Lowest Cost Silver Plan Calculator available at https://dchealthlink.com/tax-info. 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 advanced premium tax credit (APTC) and the months you received the credit.

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). Most plans sold on DC Health Link included 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 advanced premium tax credit. 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 calculator at https://dchealthlink.com/individuals/tax-info. *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 the age a person enrolled in premium tax credits was on the first day they had coverage that 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 as a discount for a given month off of your premium. This will have to be reconciled when you file your taxes. If you did not receive this discount on your invoice, you should submit a copy of that invoice and ask for a correction. If you did receive it, and it is not listed here, you should also submit your invoice and ask for a correction.