560120

Form **1095-B**

Department of the Treasury
Internal Revenue Service

Health Coverage

Do not attach to your tax return. Keep for your records.
Information about Form 1095-B and its separate instructions is at www.irs.gov/form1095b.

☐ VOID
☐ CORRECTED

OMB No. 1545-2252

2020

Part I Covered Individual

1 Name of responsible individual	2 Social security number (SSN)	3 Date of birth (if SSN is not available)
SANJAYKUMAR H PATEL	###-##-5343	

4 Street address	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
1816 E ELM ST	ANAHEIM	CA	92805-4342

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

Part II Health Coverage Issuer

9 Name	10 Employer identification number (EIN)	11 Contact Telephone number
Department of Health Care Services	68-0317191	1-844-253-0883 or TTY 1-844-357-5709

12 Street address (including room or suite no.)	13 City or town	14 State or province	15 Country and ZIP or foreign postal code
1501 Capitol Avenue, MS 4607, P.O. Box 997417	Sacramento	CA	95899-7417

Part III Covered Individual

(a) Name of covered individual	(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
16 SANJAYKUMAR H PATEL	###-##-5343		X	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

17 Case Number	18 Client Index Number (CIN)	19 Coverage provided on this Form 1095-B is current as of the date below:
30-1B4Q041	96043493F	11/30/2020

Instructions

Part I: This section will contain the personal information from the Medi-Cal record for the person receiving health coverage for the tax year shown in the upper right corner of this form. This information should be correct. If not, please contact your county human service agency to update your record and request a new corrected Form 1095-B.

Part II: This section contains the information for DHCS, who is reporting your health coverage to the IRS. You may use the contact phone number to reach a live agent at our helpdesk that will provide answers to questions you may have about this form or our reporting process.

Part III: This section will show the person's months of coverage. If the person has all twelve months of coverage, box (d) will be marked. If not, box (e) will show the separate months this person had health coverage that met the requirement for the given tax year.

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OMB No. 1545-2252

2020

Part I Covered Individual

1 Name of responsible individual	2 Social security number (SSN)	3 Date of birth (if SSN is not available)
HEENA PATEL	###-##-6458	

4 Street address	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
1816 E ELM ST	ANAHEIM	CA	92805-4342

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

Part II Health Coverage Issuer

9 Name	10 Employer identification number (EIN)	11 Contact Telephone number
Department of Health Care Services	68-0317191	1-844-253-0883 or TTY 1-844-357-5709

12 Street address (including room or suite no.)	13 City or town	14 State or province	15 Country and ZIP or foreign postal code
1501 Capitol Avenue, MS 4607, P.O. Box 997417	Sacramento	CA	95899-7417

Part III Covered Individual

(a) Name of covered individual	(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
16 HEENA PATEL	###-##-6458		X	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

17 Case Number	18 Client Index Number (CIN)	19 Coverage provided on this Form 1095-B is current as of the date below:
30-1B4Q041	93219804F	11/30/2020

Instructions

Part I: This section will contain the personal information from the Medi-Cal record for the person receiving health coverage for the tax year shown in the upper right corner of this form. This information should be correct. If not, please contact your county human service agency to update your record and request a new corrected Form 1095-B.

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Department of the Treasury
Internal Revenue Service

Health Coverage

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☐ CORRECTED

OMB No. 1545-2252

2020

Part I Covered Individual

1 Name of responsible individual	2 Social security number (SSN)	3 Date of birth (if SSN is not available)
RIYA S PATEL	###-##-3334	

4 Street address	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
1816 E ELM ST	ANAHEIM	CA	92805-4342

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

Part II Health Coverage Issuer

9 Name	10 Employer identification number (EIN)	11 Contact Telephone number
Department of Health Care Services	68-0317191	1-844-253-0883 or TTY 1-844-357-5709

12 Street address (including room or suite no.)	13 City or town	14 State or province	15 Country and ZIP or foreign postal code
1501 Capitol Avenue, MS 4607, P.O. Box 997417	Sacramento	CA	95899-7417

Part III Covered Individual

(a) Name of covered individual	(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
16 RIYA S PATEL	###-##-3334		X	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

17 Case Number	18 Client Index Number (CIN)	19 Coverage provided on this Form 1095-B is current as of the date below:
30-1B4Q041	96546983F	11/30/2020

Instructions

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