012IMBSTANDARDBW0012008-07767-02





Form MA 1099-HC Individual Mandate Massachusetts Health Care Coverage

2022
Massachusetts
Department of
Revenue

Name of insurance company or administrator UnitedHealth Group	2 FID 96000	number of insurance co. or administrator 00161	
3 Name of subscriber PREMCHAND RAVELLA	4 Date of birth 18SEP1993	5 Subscriber number 09891622821476072404	
120 COMMERCE WAY APT 531 WO	ty/Town BURN	8 State 9 Zip MA 018010000	
Full-year minimum creditable coverage? If No, check months with minimum creditable coverage: Corrected:			
		X Sept. X Oct. X Nov. X Dec. N	
a. Name of dependent	Date of birth	Subscriber number	
Full-year minimum creditable coverage? If No, check months w	vith minimum creditable co	overage: Corrected:	
Yes No Jan. Feb. Mar. Apr. May	June July Aug.	Sept. Oct. Nov. Dec.	
b. Name of dependent	Date of birth	Subscriber number	
Full-year minimum creditable coverage? If No, check months w	vith minimum creditable co	overage: Corrected:	
Yes No Jan. Feb. Mar. Apr. May	June July Aug.	Sept. Oct. Nov. Dec.	
c. Name of dependent	Date of birth	Subscriber number	
Full-year minimum creditable coverage? If No, check months w	vith minimum creditable co	overage: Corrected:	
Yes No Jan. Feb. Mar. Apr. May [June July Aug.	Sept. Oct. Nov. Dec.	
d. Name of dependent	Data of bloth	Code a selle se se se le se	
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