Form MA 1099-HC Individual Mandate Massachusetts Health Care Coverage

2022
Massachusetts
Department of
Revenue

Tracking #: 398567			2 FID number of insurance	e co or administrator	
1 Name of insurance company	y or administrator		2 FID number of insurance	e co. or administrator	
Tufts Associated Health M	Iaintenance		04-2674079		
3 Name of subscriber		4 Date of birth	5 Subscriber number		
LAKSHAY DEWAN		04/22/1993	992725134	ate 9 Zip	
6 Street address		7 City/Town	8 Sta	ite 5 Zip	
					00000
211 N WASHINGTON S	T	NORTH ATTLEE			orrected:
Full-year minimum creditable	coverage? If No, check mon	ths with minimum credi	table coverage:		
X Yes No	Jan. Feb. Mar.	Apr. May	June July Aug.	Sept. Oct. Nov.	Dec.
a. Name of dependent		Date of birth	1	Subscriber number	
Full waar minimum araditabl	le coverage? If No, check mon	ths with minimum credi	table coverage:	Со	rrected:
				Sept. Oct. Nov.	Dec.
Yes No	Jan. Feb. Mar.	Apr May Date of birtl		Subscriber number	
b. Name of dependent		Date of birth			
				C	orrected:
Full-year minimum creditable	le coverage? If No, check mor	ths with minimum cred	table coverage:		
Yes No	Jan. Feb. Mar.	Apr. May	June July Aug.		. Dec.
c. Name of dependent		Date of birt	h	Subscriber number	
Full-year minimum creditable	e coverage? If No, check mor	ths with minimum cred	itable coverage:		Corrected:
			June July Aug	Sept. Oct. No	v. Dec.
Yes No	Jan. Feb. Mar.	Date of birt		Subscriber number	
d. Name of dependent		Date of bill			
Full-year minimum creditable	coverage? If No, check mon	ths with minimum cred	itable coverage:		Corrected:
Yes No	Jan. Feb. Mar	Apr May _	June July Aug	Sept. Oct. No	ov. Dec.
e. Name of dependent		Date of bir	th	Subscriber number	
					O
Full-year minimum creditable	coverage? If No, check mon	ths with minimum cred	ditable coverage:		Corrected:
Yes No	Jan Feb Mar.	Apr. May	JuneJuly Au	g. Sept. Oct.	Vov. Dec.
f. Name of dependent		Date of bir	th	Subscriber number	
		the with minimum oro	ditable coverage:		Corrected:
Full-year minimum creditable				g. Sept. Oct.	
Yes No	Jan. Feb. Mar.	Apr. May Date of bir		g. Sept. Oct. Subscriber number	Vov. Dec.
g. Name of dependent		Date of bil	U1	Subscriber number	
Full-year minimum creditable	coverage? If No, check mor	ths with minimum cred	ditable coverage:		Corrected:
Yes No	Jan. Feb. Mar		June July Au	g. Sept. Oct. N	lov. Dec.
h. Name of dependent		Date of bir	th	Subscriber number	
					Corrected
Full-year minimum creditable	coverage? If No, check mor				Corrected:
Yes No	Jan. Feb. Mar	. Apr. May	JuneJuly Au	g. Sept. Oct. N	ov. Dec.