

**Form MA 1099-HC
Individual Mandate
Massachusetts Health Care Coverage**

**2023
Massachusetts
Department of
Revenue**

Tracking #: 1050820T6 2 FID number of insurance co. or administrator

AETNA 06-6033492
3 Name of subscriber 4 Date of birth 5 Subscriber number
RAVI PRAKASH BOLLEPALLI 05/11/1977 244042152
6 Street address 7 City/Town 8 State 9 Zip

8309 GREENLEAF RIDGE WAY CONROE TX 77385
Full-year minimum creditable coverage? If No, check months with minimum creditable coverage: Corrected:
 Yes No Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec.

a. Name of dependent Date of birth Subscriber number

AARAV S BOLLEPALLI 07/04/2016 244042154
Full-year minimum creditable coverage? If No, check months with minimum creditable coverage: Corrected:
 Yes No Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec.

b. Name of dependent Date of birth Subscriber number

SAMATHA ADUSUMILLI 05/10/1983 244042155
Full-year minimum creditable coverage? If No, check months with minimum creditable coverage: Corrected:
 Yes No Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec.

c. Name of dependent Date of birth Subscriber number

SOHIT S BOLLEPALLI 06/01/2013 244042156
Full-year minimum creditable coverage? If No, check months with minimum creditable coverage: Corrected:
 Yes No Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec.

d. Name of dependent Date of birth Subscriber number

Full-year minimum creditable coverage? If No, check months with minimum creditable coverage: Corrected:
 Yes No Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec.

e. Name of dependent Date of birth Subscriber number

Full-year minimum creditable coverage? If No, check months with minimum creditable coverage: Corrected:
 Yes No Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec.

f. Name of dependent Date of birth Subscriber number

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g. Name of dependent Date of birth Subscriber number

Full-year minimum creditable coverage? If No, check months with minimum creditable coverage: Corrected:
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h. Name of dependent Date of birth Subscriber number

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 Yes No Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec.

Name of dependent Date of birth Subscriber number

