

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095B for instructions and the latest information.

VOID
 CORRECTED

2023

Department of the Treasury
Internal Revenue Service

Part I Responsible Individual

1 Name of responsible individual: First name, middle name, last name

Neethu Padmanabharaju

4 Street address (including apartment no.)

1604 SW Clay St Apt 606

5 City or town

Portland

2 Social security number (SSN) or other TIN

3 Date of birth (if SSN or other TIN is not available)

6 State or province

OR

7 Country and ZIP or foreign postal code

US 97201

8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): D

Part II Information About Certain Employer-Sponsored Coverage (see instructions)

10 Employer name

11 Employer identification number (EIN)

12 Street address (including room or suite no.)

13 City or town

14 State or province

15 Country and ZIP or foreign postal code

Part III Issuer or Other Coverage Provider (see instructions)

16 Name

PACIFICSOURCE HEALTH PLANS

19 Street address (including room or suite no.)

20 City or town

21 State or province

22 Country and ZIP or foreign postal code

17 Employer identification number (EIN)

93-0245545

18 Contact telephone number

541-686-1242

555 INTERNATIONAL WAY

SPRINGFIELD

OR

US 97477

Part IV Covered Individuals (Enter the information for each covered individual.)

(a) Name of covered individual(s)
First name, middle initial, last name

(b) SSN or other TIN

(c) DOB (if SSN or other TIN is not available)

(d) Covered all 12 months

(e) Months of coverage

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Neethu

23 Padmanabharaju

1997-02-16

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For 3.000 Act and Act see

Cat. No.

Form

(2023)