

Form **1095-B**

**Health Coverage**

Department of the Treasury  
Internal Revenue Service

Do not attach to your tax return. Keep for your records.  
Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information.

VOID  
 CORRECTED

OMB No. 1545-2252

**2023**

560118

**Part I Responsible Individual**

1 Name of responsible individual—First name, middle name, last name  
 CHAKRA PRAD

2 Social security number (SSN) or other TIN  
 XXX-XX-6202

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

4 Street address (including apartment no.)  
 36175 GRAND RIVER AVE APT 101

5 City or town  
 FARMINGTON

6 State or province  
 MI

7 Country and ZIP or foreign postal code  
 USA 48335-0000

9 Reserved

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

10 Employer name

D

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  
 HEALTH ALLIANCE PLAN OF MICHIGAN

17 Employer identification number (EIN)  
 38-2242827

18 Contact telephone number  
 (800) 422-4641

19 Street address (including room or suite no.)  
 1414 EAST MAPLE ROAD

20 City or town  
 TROY

21 State or province  
 MI

22 Country and ZIP or foreign postal code  
 USA 48083-0000

**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						
23	CHAKRA PRAD	YEDIDA	XXX-XX-6202	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24	SRAVYAMALA	CHELAMKURI	XXX-XX-1234	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
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26				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60704B

01/17/2024

Form **1095-B** (2023)



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Form **1095-B**  
 Department of the Treasury  
 Internal Revenue Service

# Health Coverage

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**2023**

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**Part I Responsible Individual**

1 Name of responsible individual—First name, middle name, last name  
 CHAKRA PRAD YEDIDA  
 2 Social security number (SSN) or other TIN  
 XXX-XX-6202  
 3 Date of birth (if SSN or other TIN is not available)  
 4 Street address (including apartment no.)  
 36175 GRAND RIVER AVE APT 101 FARMINGTON  
 5 City or town  
 6 State or province  
 MI  
 7 Country and ZIP or foreign postal code  
 USA 48335-0000  
 8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): . . . . .  D  
 9 Reserved

**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  
 16 Name  
 HEALTH ALLIANCE PLAN OF MICHIGAN  
 17 Employer identification number (EIN)  
 38-2242827  
 18 Contact telephone number  
 (800) 422-4641  
 19 Street address (including room or suite no.)  
 1414 EAST MAPLE ROAD TROY MI  
 20 City or town  
 21 State or province  
 MI  
 22 Country and ZIP or foreign postal code  
 USA 48083-0000

**Part III Issuer or Other Coverage Provider (see instructions)**

**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
23	CHAKRA PRAD	YEDIDA	XXX-XX-6202	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24	SRAVYAMALA	CHELAMKURI	XXX-XX-1234	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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26				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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CHAKRA PRAD

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XXX-XX-6202

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36175 GRAND RIVER AVE APT 101

5 City or town  
FARMINGTON

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MI

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USA 48335-0000

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

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**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.)

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**Part III Issuer or Other Coverage Provider (see instructions)**

16 Name

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