Form 1095-B
Department of the Treasury
Internal Revenue Service

Health Coverage

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

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OMB No. 1545-2252

2023

For Driver Act and Department of the Control of the	28	27	26	25	24 SRAVYAMALA	23 CHAKRA PRAD		(a) Name of cov First name, middl	Part IV Covered	1414 EAST MAPLE ROAD	19 Street address (including room or suite no.)	HEALTH ALLIANCE PLAN OF MICHIGAN		Part III Issuer o	12 Street address (including room or suite no.)	io Employer name	art II	פונ		36175 GRAND RIVER AVE APT 101	4 Street address (including apartment no.)	CHAKRA PRAD
					CHELAMKURI	YEDIDA		(a) Name of covered individual(s) First name, middle initial, last name	Individuals (Enter	6	ng room or suite no.)	N OF MICHIGAN		r Other Coverage	ng room or suite no.)		tion About Certain	g origin or the Health C	Origin of the Health	VE APT 101	g apartment no.)	AKRA PRAD
see senarate					XXX-XX-1234	XXX-XX-6202		(b) SSN or other TIN	Covered Individuals (Enter the information for each covered individual.)	П	2			Issuer or Other Coverage Provider (see instructions)	13		Information About Certain Employer-Sponsored Coverage (see instructions)	Enter literal unitarity or girl of the Health Coverage (see instructions for codes):		Ţ	5	
netrictions						8		(c) DOB (if SSN or other (d) Covered TIN is not available) all 12 months	each covered inc	TROY	20 City or town		2010	uctions)	3 City or town		pred Coverage (s	s for codes):		FARMINGTON	City or town	YEDIDA
						×		(d) Covered all 12 months	lividual.)								ee instru		7			
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					×		Feb		7	100	State or province	38-2242827	Employe		State or province				Reserved		State or province	XXX-XX-6202
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							Sep	Y	100		P or forei		Contact telephone number		P or forei	ification i					or foreic	Date of billing (in Solve of bullet THV is not available)
							Oct		8		22 Country and ZIP or foreign postal code		P		Country and ZIP or foreign postal code	Employer identification number (EIN)					Country and ZIP or foreign postal code	
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Internal Revenue Service		Go to www.irs.gov/F	Go to www.irs.gov/Form1095B for instructions and the latest information.	tions and	the lat	est info	rmation				001111111111111111111111111111111111111		_	[[
Part I Responsi	Responsible Individual															
1 Name of responsible ind	Name of responsible individual-First name, middle name, last name	name, last name			2	Social sec	curity nun	Social security number (SSN)) or other TIN		3 Date o	f birth (if	SSN or o	ther TIN i	Date of birth (if SSN or other TIN is not available)	able)
CHAKRA PRAD			YEDIDA		×	XXX-XX-6202	02									
4 Street address (including apartment no.)	apartment no.)	5	City or town		6	State or province	province				7 Count	Country and ZIP or foreign postal code	P or forei	gn posta	code	
36175 GRAND RIVER AVE APT 101	/E APT 101	F/	FARMINGTON							_	JSA 483	USA 48335-0000				
8 Enter letter identifying	Origin of the Health C	Enter letter identifying Origin of the Health Coverage (see instructions for codes): .	s for codes):		9	Reserved	_									
Part II Informati	ion About Certair	Information About Certain Employer-Sponsored Coverage (see instructions)	ored Coverage (se	e instru	ctions											
10 Employer name								9			11 Empl	Employer identification number (EIN)	tification	number (EIN)	
12 Street address (including room or suite no.)	g room or suite no.)	13	3 City or town		14	State or province	province				15 Coun	Country and ZIP or foreign postal code	IP or fore	ign posta	code	
Part III Issuer or	Other Coverage	Issuer or Other Coverage Provider (see instructions)	uctions)							7			50			
16 Name HEALTH ALLIANCE PLAN OF MICHIGAN	N OF MICHIGAN				38-	17 Employe 38-2242827	er identific	Employer identification number (EIN) 242827	mber (EII)		18 Contact tele (800) 422-4641	Contact telephone number 1) 422-4641	nun enor	ber		
19 Street address (including room or suite no.)	g room or suite no.)	2	20 City or town		21	State or	21 State or province			b	2 Coun	22 Country and ZIP or foreign postal code	IP or fore	ign posta	code	
1414 EAST MAPLE ROAD	D	П	TROY		M					_	JSA 480	USA 48083-0000				
Part IV Covered	Individuals (Enter	Covered Individuals (Enter the information for each covered individual.)	each covered indi	vidual.)									1			
(a) Name of covered individual(s) First name, middle initial, last name	ered individual(s) e initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other (d) Covered TIN is not available) all 12 months	(d) Covered all 12 months	6.					Months	(e) Months of coverage	ge				
			100		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23 CHAKRA PRAD	YEDIDA	XXX-XX-6202		×												
24 SRAVYAMALA	CHELAMKURI	XXX-XX-1234			×	×	×	×	×	×	×	×				
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27																
28																
For Privacy Act and Panerwork Reduction Act Notice, see separate instructions.	Service Beduction Ac	Notice see separate	instructions.				2	Cat No Coron	1		01/17/2024	2024		Eon	1005	Form 1095-R /2021





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Part I Responsible Individual	e Individual							1								
1 Name of responsible individual-First name, middle name, last name	ual-First name, middle	name, last name			2	Social se	curity nun	nber (SSN	2 Social security number (SSN) or other TIN	TIN 3		birth (if S	Date of birth (if SSN or other TIN is not available)	er TIN is	not avails	able)
CHAKRA PRAD			YEDIDA		×	XXX-XX-6202	02									
4 Street address (including apartment no.)	artment no.)		5 City or town		6	State or province	province			7	Count	y and ZIF	Country and ZIP or foreign postal code	n postal	code	
36175 GRAND RIVER AVE APT 101	PT 101		FARMINGTON							_	USA 48335-0000	35-0000				
8 Enter letter identifying Origin of the Health Coverage (see instructions for codes):	igin of the Health Co	overage (see instruction	ons for codes):		9	Reserved										
Part II Information	About Certain	Employer-Spon	Information About Certain Employer-Sponsored Coverage (see instructions)	ee instru	ctions											
10 Employer name										11		yer ident	Employer identification number (EIN)	umber (E	Z	
12 Street address (including room or suite no.)	om or suite no.)		13 City or town		14	State or province	province			15		ry and ZI	Country and ZIP or foreign postal code	gn postal	code	
Part III Issuer or Ot	ther Coverage	Issuer or Other Coverage Provider (see instructions)	tructions)													
16 Name					17	Employ	er identific	ation nur	Employer identification number (EIN)	1	18 Conta	ct telepho	Contact telephone number	B		
HEALTH ALLIANCE PLAN OF MICHIGAN	FMICHIGAN				38-	38-2242827	7			(8	(800) 422-4641	4641				
19 Street address (including room or suite no.) 1414 EAST MAPLE ROAD	om or suite no.)		TROY		Z 21		State or province			C 12	22 Country and Z USA 48083-0000	ry and ZII 3-0000	22 Country and ZIP or foreign postal code USA 48083-0000	jn postal	code	
Part IV Covered Inc	dividuals (Enter	the information f	Covered Individuals (Enter the information for each covered individual.)	lividual.)						9		-	1			8
(a) Name of covered individual(s) First name, middle initial, last name	individual(s) ial, last name	(b) SSN or other TIN	N (c) DOB (if SSN or other (d) Covered TIN is not available) all 12 months	(d) Covered all 12 months					(e)	Months	(e) Months of coverage	6				
					Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23 CHAKRA PRAD	YEDIDA	XXX-XX-6202		×												
24 SRAVYAMALA	CHELAMKURI	XXX-XX-1234			×	×	×	×	×	×	×	×				
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or Privacy Act and Paperwork Reduction Act Notice, see separate instructions.	ork Reduction Act	Notice, see separat	e instructions.				2	Cat. No. 60704B	048		01/17/2024	024		Form	1095-	Form 1095-B (2023)



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Part I Responsible Individual	Individual							ľ					-			
of r	-First name, middle	e name, last name			2	Social se	curity nur	2 Social security number (SSN) or other TIN	V) or other	_	3 Date c	Date of birth (if SSN or other TIN is not available)	SSN or o	ther TIN is	s not avai	able)
CHAKRA PRAD			YEDIDA		×	XXX-XX-6202	02									
4 Street address (including apartment no.) 36175 GRAND RIVER AVE APT 101	nent no.) T 101		5 City or town		6	State or province	province				7 Coun	7 Country and ZIP or foreign postal code	P or forei	gn postal	code	
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12 Street address (including room or suite no.)	or suite no.)		13 City or town		4	State or	State or province				15 Coun	Country and ZIP or foreign postal code	IP or fore	ign posta	code	
Part III Issuer or Oth	er Coverage	Issuer or Other Coverage Provider (see instructions)	ructions)		7				THE SECTION				No.			
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19 Street address (including room or suite no.)	or suite no.)		20 City or town		21		State or province			b)	2 Coun	22 Country and ZIP or foreign postal code	IP or fore	gn posta	code	
Part IV County India	id of (Esta	Coursed Individuals (Enter the information for each account individual)	Thort services in	1	IVI						OOA 40003-0000	00-000				
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					Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23 CHAKRA PRAD	YEDIDA	XXX-XX-6202		×												
24 SRAVYAMALA	CHELAMKURI	XXX-XX-1234			×	×	×	×	×	×	×	×				
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