Form 1095-B Correction/ Coverage Discrepancy Form

Mail to: 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Send it by secure fax to: 916.568.0334
Questions? 916.563.2250 | 888.563.2250 toll-free | 888.877.5378 TDD/TTY

SUBSCRIBER NAME _____ **WHA SUBSCRIBER ID#** _____

Email Address _____

Home Phone _____ Work Phone _____

REASON FOR CORRECTION

SUBSCRIBER: Indicate correct information for the ***subscriber***

❍ Name _____

❍ Date of Birth _____

❍ Social Security Number _____

❍ Address* _____

_____

DEPENDENT #1

Indicate correct information for the following member ID

WHA Member ID# _____

❍ Name _____

❍ Date of Birth _____

❍ Social Security Number _____

DEPENDENT #2

Indicate correct information for the following member ID

WHA Member ID# _____

❍ Name _____

❍ Date of Birth _____

❍ Social Security Number _____

DEPENDENT #3

Indicate correct information for the following member ID

WHA Member ID# _____

❍ Name _____

❍ Date of Birth _____

❍ Social Security Number _____

Use additional forms to provide corrected information for additional dependents, when necessary

REASON FOR DISCREPANCY

❍ Subscriber never received Form 1095-B from Western Health Advantage for Tax Year 20____

❍ Subscriber's health coverage was terminated — Indicate termination date: _____

❍ Wrong month(s) of coverage is/are listed for subscriber — Indicate incorrect month(s): _____

❍ Wrong month(s) of coverage is/are listed for dependent(s) — Indicate correct month(s): _____

❍ Not all months of coverage are listed for subscriber — Indicate additional month(s): _____

❍ Not all months of coverage are listed for dependent(s) — Indicate additional month(s): _____

❍ Dependent(s) is/are missing — Indicate name(s): _____

_____

Subscriber Name _____ Signature _____ Date _____

IF ABOVE SUBSCRIBER IS ENROLLED IN GROUP COVERAGE WITH WHA: To the best of my knowledge the information contained is true and accurate. I hereby attest that employee and dependent(s) submitted to WHA for coverage meet all eligibility requirements set forth in the Group Service Agreement between WHA and the employer.

Employer Name _____ Signature _____ Date _____

*An amended Form 1095-B will not be sent for address changes. *Allow 7 to 10 business days to receive an amended form for all other corrections and discrepancies.*