

1095-B Handouts
IMAC
November 19, 2015

The following pages contain examples of:

- 1095-B initial cover letter
- 1095-B form and instructions
- 1095-B Information page in the CWW 1095-B Admin Tool

Please note that these are mock-ups and are subject to change.

STATE OF WISCONSIN - 1095-B
PO BOX 5236
JANESVILLE WI 53547 5236

Mailing Date: 11/02/2015

000001

Member Name
123 Main St.
Anytown, WI 12345-1234



State of Wisconsin

ID #: 7111436571

1095-B Form Assistance
Phone: 1-866-667-9419

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DHS is an equal opportunity employer and service provider. If you need an interpreter or this letter explained to you in your own language, or if you need help accessing our programs or need this material in a different format because of a disability, please call 1-866-667-9419. These services are free.

Important Tax Information for Member Name

The federal government requires the State of Wisconsin to send a 1095-B form to every person in Wisconsin who had health care coverage from BadgerCare Plus, Medicaid, or another State of Wisconsin health care program that provided minimum essential coverage in 2015. Minimum essential coverage is the type of health care coverage a person must have to avoid the federal fee for not having health insurance coverage that is required by the Affordable Care Act.

Enclosed is an IRS 1095-B form for Member Name

If your household files a federal income tax return for 2015, you may need to indicate on the tax return whether Name had health insurance coverage during all of 2015. The information on the enclosed 1095-B form can help you answer this question.

Note: Each person in your household who had minimum essential coverage through the State of Wisconsin in 2015 will get his or her own 1095-B form.

Refer to the instructions on the back of the form for information about using this 1095-B form to complete a tax return. Be sure to keep the form with your other important tax documents. You can also get additional information about this form by visiting irs.gov or contacting a tax professional.

If you have questions about the health care coverage listed on the 1095-B form, please call 1-866-667-9419.

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SYS TEST

Form 1095-B Department of the Treasury Internal Revenue Service	Health Coverage	<input type="checkbox"/> VOID	OMB No. 1545-2252
		<input type="checkbox"/> CORRECTED	2015
▶ Information about Form 1095-B and its separate instructions is at www.irs.gov/form1095b .			

Part I Responsible Individual			
1 Name of responsible individual Member Name		2 Social security number (SSN) XXX-XX-9745	3 Date of birth (If SSN is not available)
4 Street address (including apartment no.) 123 Main St.	5 City or town ANYTOWN	6 State or province WISCONSIN	7 Country and ZIP or foreign postal code USA 12345-1234
8 Enter letter identifying Origin of the Policy (see instructions for codes): ▶ <input type="text" value="C"/>		9 Small Business Health Options Program (SHOP) Marketplace identifier, if applicable	

Part II 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 State of Wisconsin Department Of Health Services Division of Health Care Access and Accountability		17 Employer identification number (EIN) 39-6006469	18 Contact telephone number 1-866-667-9419
19 Street address (including room or suite no.) 1 West Wilson Street PO Box 309	20 City or town Madison	21 State or province WI	22 Country and ZIP or foreign postal code USA 53701

Part IV Covered Individuals (Enter the information for each covered individual(s).)															
(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN 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 Member Name	XXX-XX-9745		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>							

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60704B Form 1095-B (2015)

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Instructions for Recipient

This Form 1095-B provides information needed to report on your income tax return that you, your spouse (if you file a joint return), and individuals you claim as dependents had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year. Individuals who don't have minimum essential coverage and don't qualify for an exemption may be liable for the individual shared responsibility payment.

Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage, see www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision.

TIP Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.

Part I. Responsible Individual, lines 1–9. Part I reports information about you and the Coverage.

Lines 2 and 3. Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

CAUTION If you don't provide your SSN or other TIN and the SSNs or other TINs of all covered individuals to the sponsor of the coverage, the IRS may not be able to match the Form 1095-B with the individuals to determine that they have complied with the individual shared responsibility provision.

Line 8. This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage

TIP If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange) that coverage will be reported on a Form 1095-A rather than a Form 1095-B.

Line 9. This line will be blank for 2015.

Part II. Employer-Sponsored Coverage, lines 10–15. This part will be completed by insurance company if an insurance company provides your employer-sponsored health coverage. It provides information about the employer sponsoring the coverage. If your coverage is not insured employer coverage, this part will be blank.

Part III. Issuer or Other Coverage Provider, lines 16–22. This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.

Part IV. Covered Individuals, line 23. This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if an SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, you will receive one or more additional Forms 1095-B that continue Part IV.

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- Navigation Menu
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1095-B Health Coverage

1095-B Details

Form Details

*Tax Year: 2016 *IRS Form Type: Initial

Most Recent Date Form Sent to Member: 02/20/2017 Date Form Filed with IRS: 03/26/2017

Last Updated: 06/07/2017 Updated By: Y SRIVASTAVA (XCTW26)

Individual Information

*First Name: TESTMEC MI: T *Last Name: FORMDET Suffix: *Birth Date: 01/01/2001

SSN: 964-01-1234 *Gender: MALE MA ID: 1234567890 CARES PIN: 1234567890 CARES CASE: 2015201520

Additional Information

*County / Tribe: 13 - DANE COUNTY *Language: E - ENGLISH Foster Care Indicator:

Mailing Address Information

Address Line 1: C/O John Doe

Address Line 2: 433 W Washington Ave

Address Line 3: Apt 202

*City: MADISON *State: WI - WISCONSIN

*ZIP: 53212 - 2703 Contact Phone: 888 252 9633

Minimum Essential Coverage (MEC) Information

*Covered for all 12 months: No Override Reason:

Months of Coverage (if covered for all 12 months is No)

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Yes	Yes	No	Yes	Yes							

Comments

Comment:
 Current Size = 0 characters (1000 characters max.)

Most Recent Mailing Information

Latest Form for the Tax Year

Mailing Date	Description	Tax Year	Language	Send Duplicate	View
1/13/2017	1095-B Health Coverage - Initial	2016	English		

To-Be-Processed Mailing

Description	Request Date	Request Time	Duplicate	Preview
1095-B Health Coverage - Initial	06/07/2017	14:06:23	Yes	

Tax Year: YYYY Updated on or before: MM/DD/YYYY Go