REQUEST or DISPUTE
Form 1095-B

You may use this form to dispute information on Form 1095-B or to request Form 1095-B, if you did not receive one. L.A. Care (also known as the Local Initiative Health Authority for Los Angeles County) will review and verify any corrections or updates you provide on this form. If L.A. Care determines the updated information you provided is correct, a new corrected Form 1095-B form will be sent to you. We may also need to contact you to confirm any information you provide.

Please complete and sign this form. If you have any questions, please call L.A. Care Member Services. L.A. Care representatives are available 24 hours a day, 7 days a week.

PASC-SEIU (Homecare Workers Health Care Plan) Member Services **1.888.839.9909** (TTY **711**)

L.A. Care Covered™ and L.A. Care Covered *Direct*™ Member Services **1.855.270.2327** (TTY **711**)

Subscriber/Responsible Party Information

Benefit Year Requested:		**Please select your plan:** ☐ L.A. Care Covered™ ☐ L.A. Care Covered *Direct*™ ☐PASC-SEIU Homecare Workers Health Care Plan		
Name (Last, First)				
Date of birth (month/day/year)		Member ID #		
Physical Address (including apt number)		City	State	ZIP Code
Mailing Address (if different from above)		City	State	ZIP Code
Day Time Phone #	Evening Phone #	Email Address		
Fax Number:				

Household Members. *(PASC-SEIU members do not need to complete this section.)*

L.A. Care Covered™ and L.A. Care Covered *Direct*™ members must list the names of all household members covered under this plan, including yourself, if covered. If more than four (4) members are covered, please attach an additional page.

Member #1 (Last, First)	Member #3 (Last, First)
Member #2 (Last, First)	Member #4 (Last, First)

Reason For Request/Dispute (If this is a dispute, please review your copy of Form 1095-B and tell us the reasons for your dispute by checking one or more boxes below.)

☐ Never received Form 1095-B. Please send my Form 1095-B via "Delivery Method" selection below.	☐ The "Responsible Individual" information is incorrect. Please write the correct information under the "Subscriber/Responsible Party" section above.
☐ There are missing household members or incorrect names Please write the correct names of all members covered in this plan, in the "Household Member" section above.	☐ The policy start date or end date shown is incorrect. Please write the correct start and end dates below. _____
☐ The months of coverage listed are incorrect. Please write the correct months you had coverage below. _____	
☐ Other reason. Please list reason for dispute and the correction.	

Return Signed Form and Return to:

Mail: L.A. Care Health Plan Attn: Medical Payments Systems and Services 1055 W 7th Street, 10th Floor Los Angeles, CA 90017	**Fax**: L.A. Care Health Plan Attn: Medical Payments Systems and Services Re: "Request or Dispute Form 1095-B" 213.438.6105

Delivery Method for Your Form 1095-B

☐ **United States Postal Service** I authorize L.A. Care Health Plan to send me a copy of my Form 1095-B via U.S. Postal Services to the mailing address listed above.

☐ **Secure Email** I authorize L.A. Care Health Plan to send me a copy of my Form 1095-B via secure email to the email address listed above

☐ **Secure Fax** I authorize L.A. Care Health Plan to send me a copy of my Form 1095-B via Fax to the Fax Number listed above.

Authorization *(required)*

I hereby authorize L.A. Care Health Plan to provide me a copy of my Form 1095-B for the Benefit Year indicated above.

Name _____ Signature _____ Date _____

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