



**COMPLETE SCHEDULE HC-CS  
TO REPORT ADDITIONAL  
INSURANCE COMPANIES**

FIRST NAME

M.I.

LAST NAME

SOCIAL SECURITY NUMBER

\_\_\_\_\_

\_\_\_\_\_

**Schedule HC-CS Health Care Information Continuation Sheet**

**2016**

Complete Schedule HC-CS, Health Care Information Continuation Sheet, if you fill in the **Full-Year MCC** or **Part-Year MCC** oval(s) in line 3 of Schedule HC and had more than two private health insurance companies. **Note:** Your two most recent health insurance companies should be reported on Schedule HC, line(s) 4f and/or 4g. Fill out the information below, using Form MA 1099-HC, to report the information from your additional insurance companies.

**PART A. YOUR HEALTH INSURANCE**

3. NAME OF THIRD INSURANCE COMPANY OR ADMINISTRATOR IF NECESSARY (from box 1 of Form MA 1099-HC)

\_\_\_\_\_

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC)

\_\_\_\_\_

SUBSCRIBER NUMBER (from Form MA 1099-HC)

\_\_\_\_\_

4. NAME OF FOURTH INSURANCE COMPANY OR ADMINISTRATOR IF NECESSARY (from box 1 of Form MA 1099-HC)

\_\_\_\_\_

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC)

\_\_\_\_\_

SUBSCRIBER NUMBER (from Form MA 1099-HC)

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**PART B. SPOUSE'S HEALTH INSURANCE** (you must complete even if covered under same insurance plan)

3. NAME OF THIRD INSURANCE COMPANY OR ADMINISTRATOR IF NECESSARY FOR SPOUSE (from box 1 of Form MA 1099-HC)

\_\_\_\_\_

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC)

\_\_\_\_\_

SPOUSE'S SUBSCRIBER NUMBER (from Form MA 1099-HC)

\_\_\_\_\_

4. NAME OF FOURTH INSURANCE COMPANY OR ADMINISTRATOR IF NECESSARY FOR SPOUSE (from box 1 of Form MA 1099-HC)

\_\_\_\_\_

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC)

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SPOUSE'S SUBSCRIBER NUMBER (from Form MA 1099-HC)

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