



COMMONWEALTH of VIRGINIA

Department of Health

PO BOX 2448
RICHMOND, VA 23218

TTY 7-1-1 OR
1-800-828-1120

REQUEST TO PAY TAX CREDIT LIABILITY

This form is to be completed if you would like to request the Virginia (VA) Medication Assistance Program to pay your tax credit liability due to over payment of Premium Tax Credit – that is, your monthly health insurance premium in the past year was less than it should have been based on your income and now you must pay the difference.

****The program is unable to pay this tax penalty to anyone who has received a tax refund****

Date submitted: _____

Name: _____ D.O.B. _____

Street Address: _____

Town/City: _____ State: VA Zip: _____

The best way to contact me during business hours is: Cell phone: _____

Home phone: _____

Work phone: _____

I have enclosed the following required documents:

- Copies of pages 1 and 2 of my current IRS Form 1040, 1040A, or 1040NR
- Copy of IRS Form 8962
- Copy of IRS Form 1095-A

Signature: _____ Date: _____

For Office Use Only:	
Date Received: _____	Reviewed by: _____
Amount Reimbursed: \$ _____	
Reason for Denial: _____	