ATTACHMENT 2

Countermeasures Injury Compensation Program (CICP)

Certification of Status: Unreimbursed Medical Expenses

Case Number: _____

This Certification will assist the Countermeasures Injury Compensation Program (CICP) in determining benefits. Please complete the statement below that applies to your case, and print and sign your name below. For guidance on which statement to complete, see Section I of Attachment 1 – "Documentation Required to Reimburse or Pay for Medical Expenses and/or Lost Employment Income."

Option 1

I certify that_____ i***s not*** requesting payment for
(injured countermeasure recipient's name)

unreimbursed medical expenses for injuries detailed in the CICP decision letter dated [ ].

Option 2

I certify that _____ is requesting payment for unreimbursed
(injured countermeasure recipient's name)

medical expenses for injuries detailed in the CICP decision letter dated [ ] and

was not covered by a third-party payer of unreimbursed medical expenses during the period of

_____ to _____.
(date of no coverage) (date no coverage ended or the present)

Option 3

I certify that _____ is requesting payment for unreimbursed
(injured countermeasure recipient's name)

medical expenses for injuries detailed in the CICP decision letter dated [ ] and

was covered by a third-party payer of unreimbursed medical expenses during the period of

_____ to _____.
(date of coverage) (date coverage ended or the present)

By signing this form, I hereby certify that the information provided in this Certification is true and accurate to the best of my knowledge. Further, I understand that false statements or claims made in connection with this Certification, including subsequent information and documentation submitted in connection with this Certification, may result in any remedy, including civil remedies, available by law to the United States. I will provide updated information (including, but not limited to medical records, employment income records, and change of address) until the Program has made its final benefits decision.

_____ _____
Name of Requester (Please print) Name of Representative (if applicable)

_____ _____
Signature of Requester or Representative Date