ATTACHMENT 2

OMB Number: 0915-0334
Expiration date: (04/30/2026)

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."

The CICP requests that you send all documentation within 60 days of the date of this letter. Please submit the requested form online at **injurycompensation.hrsa.gov (preferred)**. If you are unable to submit the form electronically, please send it to the following address:

Health Resources and Services Administration
Countermeasures Injury Compensation Program
5600 Fishers Lane, 8W-25A
Rockville, MD 20857

If you have questions, please call 1-855-266-2427, email CICPBenefits@hrsa.gov, or mail them to the address above.

Option 1

I certify that_________________________________ is ***not*** requesting payment for
(injured countermeasure recipient's name)

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

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 any person who knowingly falsifies, conceals or covers up a material fact, makes a materially false, fictitious, or fraudulent statement or representation or makes or uses a false writing or document knowing it contains a materially false, fictitious or fraudulent statement or entry to obtain compensation under the CICP, or who knowingly accepts compensation to which that person is not entitled, may be subject to civil, administrative, and felony criminal penalties, which may be punishable by a fine, imprisonment or both. 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 Injured Countermeasure Recipient (Please print)

____

Name of Representative (if applicable) (Please print)

____ ____________________

Signature of Requester or Representative Date