

**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 \(preferred\)**](http://injurycompensation.hrsa.gov). 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 CICP@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