

**Countermeasures Injury Compensation Program (CICP)****Certification of Status for Administrators of the Estate: 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](http://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](mailto:CICPBenefits@hrsa.gov), or mail them to the address above.

**Option 1**

I certify that \_\_\_\_\_ is **not** requesting payment for  
(name of the administrator of the estate of  
deceased injured countermeasure recipient)

unreimbursed medical expenses for injuries detailed in [Deceased Countermeasure Recipient]’s

CICP decision letter dated [insert date].

**Option 2**

I certify that \_\_\_\_\_ is requesting payment for unreimbursed  
(name of the administrator of the estate of  
deceased injured countermeasure recipient)

medical expenses for injuries detailed in [Deceased Injured Countermeasure Recipient]’s CICP decision

letter dated [insert date] 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  
(name of the administrator of the estate of  
deceased injured countermeasure recipient)

medical expenses for injuries detailed in [Deceased Injured Countermeasure Recipient]’s CICP decision

letter dated [insert date] 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 Deceased Injured Countermeasure Recipient  
(Please print)

\_\_\_\_\_  
Name of the administrator of the estate of the Deceased  
Injured Countermeasure Recipient (Please print)

\_\_\_\_\_  
Signature of the administrator of the estate of  
Deceased Injured Countermeasure Recipient

\_\_\_\_\_  
Date