FORM 1

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

Countermeasures Injury Compensation Program (CICP)
Request for Unreimbursed Medical Expenses
Requester Category: Injured Countermeasure Recipient or Representative

Case Number: _____ (starts with CICP)

This form ~~helps the~~is used to ~~Countermeasures Injury Compensation Program (CICP)~~ determine your eligibility to receive **unreimbursed medical expenses** for medical services or items used to treat your covered injury. Please complete the statements below that apply to your case. Then, print your name, sign the form, and submit it with the required documents, if applicable. You will find the list of required documents at the end of this form.

A. Unreimbursed Medical Expenses

~~What A~~are you requesting unreimbursed medical ~~e~~expenses? (Check one)

☐ **YES** - I am requesting reimbursement or payment for **PAST and/or FUTURE** medical expenses for medical services or items used to treat my covered injury or its health complications since the onset of the injury.

*If you are requesting reimbursement or payment for past, current, and future medical expenses, please carefully read and complete the **Required Documents Checklist** included in this letter.*

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☐ **NO** - I am **not** requesting reimbursement or payment for **PAST and/or FUTURE** medical expenses for services for a covered injury or its health complications.

a. **If you checked YES:** Proceed to fill out B: Third-Party Payer Information~~Complete all steps below~~.
b. **If you checked NO:** Skip to D: Final Attestation and Acknowledgment and sign the form and submit to CICP.
c. **If you checked YES:** Complete all steps below.

B. Third-Party Payer Information

Check one: Select the box that applies to your situation.

~~☐ I certify I **do not have any or know of any third-party payers** that did have paid or may be obligated towill pay for or provide medical services or items.~~

☐ I certify that the table below includes all **third-party payers** that ~~did~~ have paid or ~~will~~ may be obligated to pay for medical services or items.

If you do have third-party payers, complete the table below listing any and all third-party payers which may include, but are not limited to health maintenance organizations, health insurance companies, workers' compensation programs, Medicare, Medicaid, Department of Veterans Affairs, military treatment facilities (MTFs), and any other entities that ~~did~~ paid or are obligated to reimburse medical expenses or provide medical services or items ~~used~~ to treat your covered injury.

If you have third-party payers, list them here:

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Third-Party Payer Organization	Account Number	Dates of Coverage	Sponsor's Name
Example: Aetna	123456789-0	1/1/1998-present	John Doe

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☐ I certify I **do not have any or know of any third-party payers** that have paid or may be obligated to pay for or provide medical services or items.

If you need additional space, please add a second page.

C. ~~Secondary~~ Payer of Last Resort Acknowledgement

Please read and acknowledge that CICP is the payer of last resort by checking both boxes.

☐ I understand benefits from the CICP are secondary to benefits ~~received or receivable~~paid or payable from third-party payers, and it may be possible that certain recipients deemed eligible will have **no eligible** medical services or items.

☐ I understand that if I receive a benefit from a third-party payer after receiving the same type of benefit~~s~~ under this Program, the CICP has the right to recover the amount of benefits received.

D. Final Attestation and Acknowledgment

By signing this form, I hereby certify that the information provided in this ~~Certification~~ Request for Unreimbursed Medical Expenses form 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. ~~I am also signing with the understanding that the CICP is a secondary payer to benefits received or receivable from third-party payers, and it may be possible that certain requesters deemed eligible will have no eligible benefits.~~

_____
Name of Injured Countermeasure Recipient (Please print)

_____ _____
Signature of Injured Countermeasure Recipient Date

~~**PUBLIC BURDEN STATEMENT** The purpose of this data collection is to gather information to allow the Secretary of Health and Human Services to determine if requesters are eligible for Countermeasure Injury Compensation Program (CICP) benefits. Requesters (or their representatives) must submit appropriate documentation forms and relevant medical records as specified in Section 42 CFR 110.50–110.53 to the CICP. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0915–0334 and it is valid until 4/30/2026. This information collection is required to obtain or retain a benefit (42 CFR Part 110). Access to these records is strictly limited to authorized users who are aware of their responsibilities under the Privacy Act and who are required to maintain Privacy Act safeguards with respect to such records. The System of Records Notice for Injury Compensation Programs, HHS/HRSA/HSB, System No. 09–15–0056, identifies authorized users. Public reporting burden for this collection of information is estimated to average 5.1 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or~~

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~~any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or paperwork@hrsa.gov. Please do not send documents related to an individual claim to paperwork@hrsa.gov.~~

UNREIMBURSED MEDICAL EXPENSES REQUIRED DOCUMENTS

Name: _____ Case #: _____

Documents for **Past** Medical Expenses **(Required)**

If you are requesting payment for unreimbursed medical expenses, ~~CICP must receive~~you must submit documents showing the medical services or items provided since the onset of the covered injury. You must submit ~~documents~~ an itemized statement from each healthcare provider or entity (e.g., hospital, doctor, pharmacy, insurance company) with the following information:

- ~~Itemized statements from each health care provider~~
- The services or items provided
- Dates of services or items provided
- Amount billed
- Amount you paid or owe
- Amount a third-party paid or owes, if applicable
- Your name on the document

Examples of documents that may show this information include Explanation of Benefits from your insurance company, medical bills, and payment receipts.

Create a Summary Sheet (Optional)

It may ~~help the CICP with timeliness~~expedite processing your claim if you put together a summary sheet of the documents you are submitting with the following information:

- Total charged: $_____
- Insurance or third-party paid: $_____
- You paid: $_____
- Still owe: $_____

Required Documents for **Future** Medical Expenses **(If applicable)**

If you are requesting reimbursement for future medical expenses, ~~CICP must receive~~you must submit a statement from each healthcare provider ~~describing the services and items that may be needed in the future and~~that describes the reasonable and necessary future medical services and items ~~that may be needed in the future, along with a treatment plan~~. This may include the following:

- Letter from healthcare provider and treatment plan
- Expected duration
- Frequency of visits
- Explains why treatment is needed and how it relates to the covered injury
- Cost estimates for such services, if available

How to send your forms and documents:

Option 1: (Preferred Method) Submit online:

1. Go to: https://cicpsubmit.hrsa.gov.
2. Upload your forms on the website.

Option 2: Send your forms via ~~posted~~ postal mail to:

Health Resources and Services Administration
Countermeasures Injury Compensation Program
5600 Fishers Lane, ~~8W-25A~~14W-18
Rockville, MD 20857

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