DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Resources and Services Administration
Countermeasures Injury Compensation Program
Rockville, Maryland 20857

August 18, 2016

b6

Case Number: b6

Dear b6 :

The Countermeasures Injury Compensation Program (CICP or Program) has reviewed your Request for Benefits Package, b6 claimed to be related to your b6 , which resulted from the b6 you received on b6

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Therefore, this letter serves as the CICP's final determination of your total CICP benefits related to b6 that resulted from your b6 .

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b6

totals $1,921.75.

This payment of $1,921.75 will be electronically transferred from the U.S. Treasury to the account you indicate on the enclosed Automated Clearing House (ACH) Payment Information Form. To receive this payment, you must complete and return the ACH Payment Information Form enclosed in Attachment 2.

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This constitutes the Program's final determination of your Request for Benefits related to your diagnosis b6 You have a right to request reconsideration of the CICP's decision. b6 your right to seek reconsideration of the Program's determination as b6 . Requests for reconsideration must be in writing, describe the reason(s) why the decision should be reconsidered, and be postmarked within 60 calendar days of the date of this decision letter. Because no new documentation will be considered in the reconsideration process, a reconsideration request may not include or refer to any documentation that was not before the Program at the time of its determination. The letter seeking reconsideration may be sent through the U.S. Postal Service, commercial carrier, or private courier service to:

Associate Administrator
Healthcare Systems Bureau
Health Resources and Services Administration
5600 Fishers Lane, Room 8W-21
Rockville, MD 20857

When the Associate Administrator receives a request for reconsideration, a qualified panel, independent of the Program, will meet to review the Program's decision. The reconsideration panel will base its recommendation on the same documentation submitted to the CICP. The panel will perform its own review of the documents submitted and of the

Program's decision. The panel will then make its own findings and submit them to the Associate Administrator. The Associate Administrator will review the panel's recommendation(s) and make a final decision, which will be sent to you. This will be the agency's final action on the request for reconsideration and will be the final determination on the request for Program benefits for the injury that is the subject of that request. Requesters may not seek review of a decision made on reconsideration.

Sincerely,

CAPT Narayan Nair, MD
Acting Director, Division of Injury Compensation Programs

8/18/16
Date

Enclosures:

b6 [redacted]

Attachment 2 -- ACH Payment Information Form with Instructions

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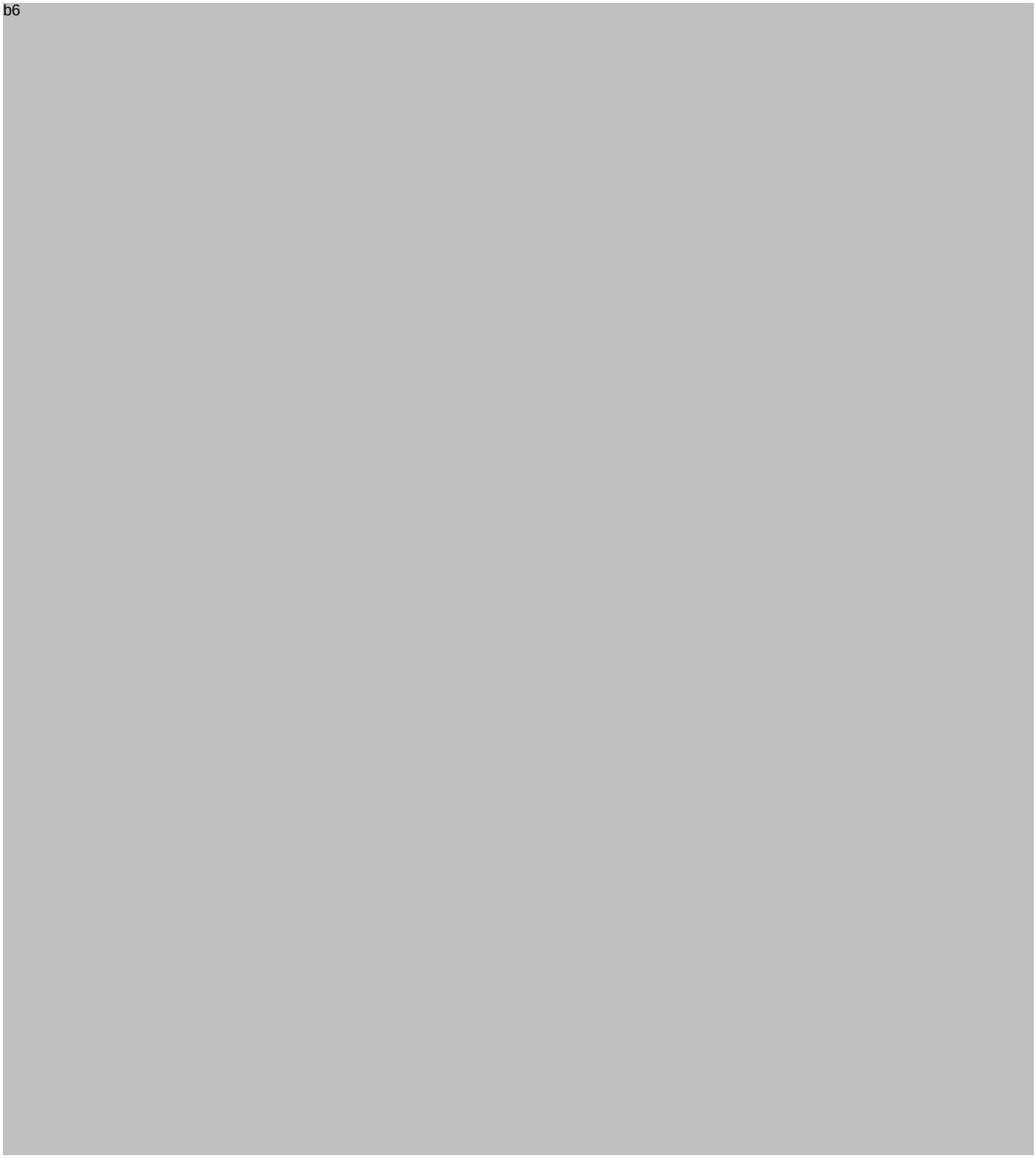

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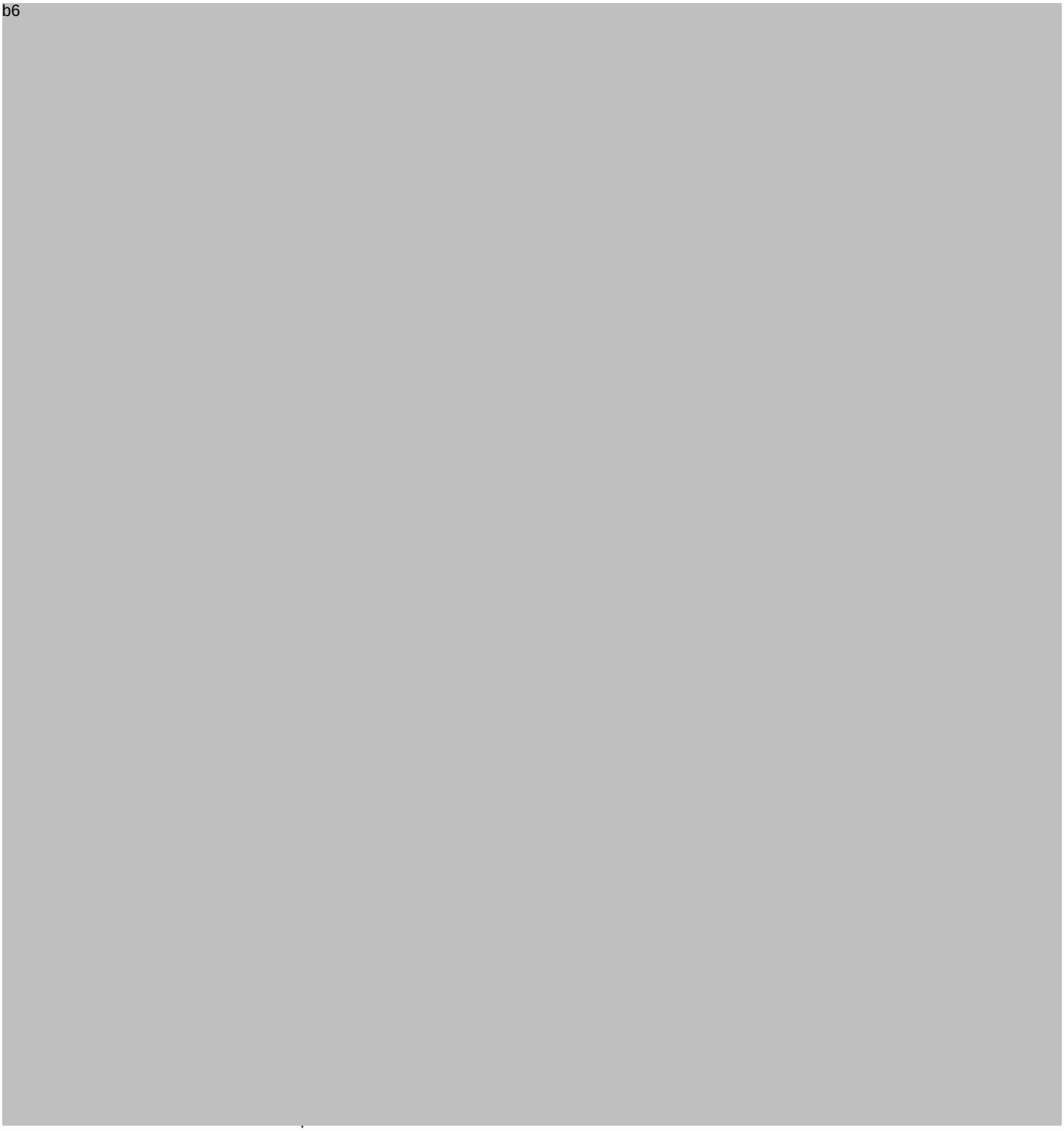


$	1,921.75

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Program Support Center
Financial Management Service
Division of Financial Operations

Payment Information Form

The information requested on this form concerns your financial institution, your account at that institution, and personal information which needs to be verified and completed.

Privacy Act Statement

The following information is provided to comply with the Privacy Act of 1974 (P.L. 93-579). All information collected on this form is required under the provisions of 31 USC 3322 and 31 CFR 210. This information will be used by the Treasury Department to transmit payment data by electronic means to your financial institution. Failure to provide the requested information may delay or prevent the receipt of payments through the automated Clearing House Payment System.

Check one: ___ Federal Employee ___ Contractor ____Vendor ____ Requester

Name _____

Address _____

_____

Telephone (____) _____

Complete one of the following: (*May be your social security number if you are an individual.)

EIN (Employer ID #) _____ TIN* (Tax ID #) _____

The following information must be completed in order to process reimbursement:

1. Name of financial institution: _____
2. Address of financial institution: _____
3. Financial institution's 9-digit ABA routing # for transfer of funds: _____
4. Depositor account title: _____
5. Depositor account number: _____
6. Type of account: _____Checking _____ Savings
7. Bank Telephone #: (___) _____

The following is to be completed by payee/requester

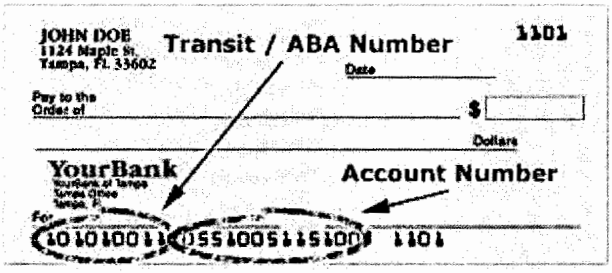
I have verified the information on this form.

Signature _____ Date _____

Instructions for Completing the Payment Information Form

- Check the appropriate category
- Fill in your name and address and telephone #
- The TIN number is also your social security number

1. Financial institution's name
2. Financial institution's address
3. The 9-digit ABA number may be obtained from your bank, and it is located on the bottom of your check. Please refer to the image below:



4. The name on the account (if joint account, your name and the other account holder)
5. Your account number
6. Identify which type of account is used at this financial institution
7. The financial institution's telephone number

Please do not forget to sign and date the form.