NHIF 8B Revised 2017

Notification Number: ……..

OUT-PATIENT CLAIM FORM

This form is designed to be completed in sections. All fields are relevant and **MUST** be completed to enable processing.

- Ensure member validity and account is valid and up to date.
- Every visit must be notified within 24 hours and the generated notification number indicated on the form.
- Payments are contingent upon validity at the time of service and providers shall be responsible for ascertaining beneficiary eligibility.
- Claims not notified shall not be reimbursed neither shall unduly filled forms be processed.
- Ensure that the invoice, pre-authorization form and the other necessary claim form requirements are attached before submission.

PART 1: PATIENT INFORMATION *To be filled by the Patient*	
Surname: Other Names:	
Members' ID No:	Member NHIF No:
Relationship: Principal Member: ☐ Spouse: ☐ Child: ☐	Gender:- Male: ☐ Female: ☐
Date of Birth: DD/MM/YEAR	Patients' Phone No:
I certify that the above information is correct. I understand that it is an offence to knowingly make any false statement for purposes of obtaining any benefit under NHIF Act. **Name:**_____ **Signature:** _____ **Date:** _____	

PART 2: HOSPITAL PARTICULARS *To be filled by the Hospital Representative*	
Facility Name:	Facility Code:
Outpatient No. (OP/No):	Scheme Type: National ☐ Managed ☐

PART 3: NATURE OF TREATMENT *To be filled by Clinician, Specialist/Consultant at the health facility.* *In cases where patient has been referred you are required to attach the copy of certified referral letter.*	
Reason for Visit: ☐ New Visit ☐ Scheduled Follow- Up Visit (Clinics) ☐ Repeat Visit (Unscheduled) ☐ Referral ☐ Emergency	
Treatment Condition: ☐ Acute ☐ Acute on Chronic ☐ Chronic ☐ Maternity ☐ Surgical ☐ Congenital	
Treatment Outcomes: (Tick as appropriate) ☐ Allowed home on treatment ☐ Admitted ☐ Referred	☐ Resolved ☐ Absconded ☐ Deceased
Clinician's/Specialist Names:	Registration No:

PART 4: TREATMENT AUTHENTIFICATION *To be filled by the Hospital Representative*		
Patients' Date of Attendance (DOA)…….. Check in Time…….. Check out Time……..		
Primary Diagnosis:		ICD 10 code:
Secondary Diagnoses: ICD 10 code (s):		
Procedure Code:	Date of Service:	
Pre-Authorization Reference Number (Where Applicable):		
Services	**Description (Procedure/Service/Supplies Issued)**	**Cost**
Consultation		
Laboratory		
Pharmacy		
Imaging		
Surgery		
Outpatient procedures		
TOTAL COST		

HOSPITAL REPRESENTATIVE: I declare that to the best of my knowledge the foregoing statements are true in every respect. I understand that it is an offence to knowingly make any false statement for purposes of obtaining any benefit under NHIF Act.

Facility stamp

Signature: _____ **Date: _____**

PART 5: PATIENT'S AUTHENTIFICATION

I certify that I have received the above treatment at the cost of Kshs …….. and that the above information is correct. I understand that it is an offence to falsify information for purposes of obtaining any benefit under NHIF Act.

Nadhibitisha ya kuwa matibabu niliyo yapokea ni ya kadri shillingi …….. za Kenya na kwamba habari niliyo andika katika fomu hii ni sahihii. Naelewa kwamba ni kosa kuandika uongo kwa madhumuni ya kupata faida kulingana na kitendo cha sheria ya shirika la kitaifa ya bima ya afya.

Names (Majina):_____

Signature (Sahihi): _____ **Date (Tarehe): _____**

NOTE

- Please be advised that reimbursement is based upon agreed terms and the medical information provided. If services, providers or dates of services change from these indicated, NHIF must be contacted/notified prior to services being rendered.
- Payment for services rendered is subject to verification of outcomes of care and beneficiary eligibility as at the date of service provision. Contractual obligations with the provider take precedence.