Form NHIF 2A
Regulation 18(1)

CONFIDENTIAL

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 08416\03\2021\366

A: PARTICULARS:

A1: Health Facility Particulars

1. Name of Health Facility **MALOLO HOSPITAL** 2.Address **P.O.Box 81 TABORA** 3.Department **GENERAL CLINIC** 4.Date Of Attendance **04.03.2021**

A2: Patient Particulars

1.Name of Patient **Shani Mangesho** 2.DOB: **01-07-1968** 3.Sex: **F** 4.Occupation: 5.Patient File No.: **1215**

6.Physical Address **Cheyo Tabora Urban** 7.Card Number:**01-8315207** 8.Authorization No: **430129442579**

9.Vote: 10.Preliminary Diagnosis (Code): **I10, E78.0, K27, M10, M10** 11.Final Diagnosis (Code): **K27, I10, R52.2**

B: Details / Cost of services

Description	Item Code	Qty	Unit Price	Amount
CONSULTATIONS				
Cons_General Practitioner_new	10001	1	7,000	7,000
SUB TOTAL				7,000
INVESTIGATIONS				
TRYGLYCERIDES	5425	1	5,000	5,000
Pottasium	5202	1	5,000	5,000
CHOLESTEROL TOTAL	5104	1	5,000	5,000
Serum Blood Creatinine	5208	1	5,000	5,000
Uric Acid	5236	1	5,000	5,000
SUB TOTAL				25,000
MEDICINES				
Lansoprazole{LAN}-INTAS{C} 30mg Cap	11581	30	325	9,750
Furosemide{B} 20mg/2ml IV/IM Injection	11573	4	750	3,000
Furosemide{Cosmos}{B}40mg Tab	11574	60	40	2,400
Amlodipine{AMLOSIN}{C} 10mg Tab	11439	30	350	10,500
Prednisolone{PREDNIKANT}{B} 5mg Tab	11622	60	50	3,000
Meloxicam{M-Cam}{C} 15mg Tab	11021	14	300	4,200
SUB TOTAL				32,850

SUPPLIES/SERVICES				
Syring 10cc	12009	1	195	195

Cannula 20G{Pink}	12038	1	1,040	1,040
SUB TOTAL				1,235
GRAND TOTAL				66,085

C: Name of attending clinician: Mubaraka H. Msigiti **Qualifications:** Medical Officer(MD) **MCT Reg. No:** 3852 **Mob. No:**

Signature:

D: Uthibitisho wa mgonjwa/Patient Certification:

Nathibitisha kuwa nimepokea huduma zilizoanishwa hapo juu na natambua kwamba ni kosa kisheria kukiri kupata matibabu ambayo hayajatolewa.

I certify that I received the above mentioned services as witnessed by my signature hereunder and I understand that it is illegal to provide false testimony.

Jina/Name: **Shani Mangesho** **Tarehe(Date)** **08-03-2021** **Namba ya Simu(Mobile No.)** **0754468176**

Signature:

Hakikisha unasaini fomu baada ya kupatiwa huduma na kupatiwa nakala ya fomu hii iliyojazwa huduma ulizopatiwa.

Make sure you receive a copy of the form you signed.

E: Description of In/Out-patient Management/any other additional Information(a separate sheet of paper can be used):.

F: Claimant Certification:

I Certify that I provided the above services.

Name: Mubaraka H. Msigiti **Signature:**

Official Stamp: 

Patient should sign the form after completion of service.

Before reffering the patient to another facility. The prescriber should be satisfied for the missing item and its alternative within the facility.

Any falsified information may subject you to prosecution in accordance with NHIF Act Cap 395.

.Original form to be submitted to NHIF Offices by the treating Health Facility(Yellow). 1st Copy to be retained by the treating Facility (Pink).

2nd Copy to be given to NHIF beneficiary (Blue)