



CONFIDENTIAL

Form NHIF 2A
Regulation 18(1)

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 04635\03\2021\2

A: PARTICULARS:

A1: Health Facility Particulars

1. Name of Health Facility DEMO DATABASE 2. Address DEMO DATABASE P.O.Box 3081, Arusha 3. Department General Outpatient Clinic 4. Date Of Attendance 04.03.2021

A2: Patient Particulars

1. Name of Patient Hashimu Kulu 2. DOB: 17-03-2004 3. Sex: M 4. Occupation: _____ 5. Patient File No.: 4534545
6. Physical Address Ngarenaro - Urban Ward Arusha 7. Card Number: 101102077629 8. Authorization No: 530129428688
9. Vote: _____ 10. Preliminary Diagnosis (Code): R39.0 11. Final Diagnosis (Code): No diagnosis entered

B: Details / Cost of services

Description	Item Code	Qty	Unit Price	Amount
CONSULTATIONS				
cons_GENERAL PRACTITIONER	10001	1	5,000	5,000
SUB TOTAL				5,000
INVESTIGATIONS				
Uric Acid	5236	1	5,000	5,000
UPT	5244	1	1,500	1,500
Urinalysis	5237	1	2,000	2,000
ECG	5078	1	15,000	15,000
SUB TOTAL				23,500

GRAND TOTAL	28,500
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C: Name of attending clinician: _____ ^{js} **Qualifications:** _____ ^{Others} **MCT Reg. No:** _____ **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: Hashimu Kulu Tarehe(Date) 04-03-2021 Namba ya Simu(Mobile No.)

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.

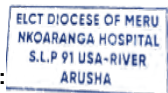
E: Description of In/Out-patient Management/any other additional Information(a separate sheet of paper can be used):.

F: Claimant Certification:

I Certify that I provided the above services.

Name: js Signature:

Official Stamp:



Patient should sign the form after completion of service.

Before referring 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)