Form NHIF 2A
Regulation 18(1)

CONFIDENTIAL

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 06878\03\2021\502

A: PARTICULARS:

A1: Health Facility Particulars

1. Name of Health Facility **SHREE HINDU HOSPITAL** 2.Address **SHREE HINDU HOSPITAL P.O.Box 3051 ARUSHA TANZANIA** 3.Department **Doctors Room 2** 4.Date Of Attendance **05.03.2021**

A2: Patient Particulars

1.Name of Patient **Graceana Temba** 2.DOB: **24-12-1986** 3.Sex: **F** 4.Occupation: 5.Patient File No.: **16433**

6.Physical Address **Moivo Arusha** 7.Card Number:**101400483487** 8.Authorization No: **130129454573**

9.Vote: 10.Preliminary Diagnosis (Code): **N73.3, N39.0, J06.9** 11.Final Diagnosis (Code): **N39.0, J06.9, K27, M13.9**

B: Details / Cost of services

Description	Item Code	Qty	Unit Price	Amount
CONSULTATIONS				
CONSULTATION GENERAL DOCTOR	10001	1	7,000	7,000
SUB TOTAL				7,000
INVESTIGATIONS				
URINE	5237	1	2,000	2,000
X-Ray - Lumbar Spine- SACRAL (AP/LAT)	5282	1	20,000	20,000
SUB TOTAL				22,000
MEDICINES				
MELOXICAM 15MG	11021	10	300	3,000
DICLOFENAC GEL	11533	1	2,000	2,000
CEPHALEXIN TABLETS 500MG	11133	15	300	4,500
SUB TOTAL				9,500

GRAND TOTAL	38,500

C: Name of attending clinician: Dr.Deodatus William **Qualifications:** **MCT Reg. No:** 0 **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: **Graceana Temba** **Tarehe(Date)** **09-03-2021** **Namba ya Simu(Mobile No.)** **0716496394**

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: Dr.Deodatus William **Signature:**

Official Stamp: ELCT DIOCESE OF MERU NKOARANGA HOSPITAL S.L.P 91 USA-RIVER ARUSHA

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)