Form NHIF 2A
Regulation 18(1)

CONFIDENTIAL

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 08416\03\2021\221

A: PARTICULARS:

A1: Health Facility Particulars

1. Name of Health Facility **MALOLO HOSPITAL** 2.Address **P.O.Box 81 TABORA** 3.Department **GYNAECOLOGY** 4.Date Of Attendance **03.03.2021**

A2: Patient Particulars

1.Name of Patient **Triphonia Biyengo** 2.DOB: **30-07-1989** 3.Sex: **F** 4.Occupation: 5.Patient File No.: **3645**

6.Physical Address **Malolo Tabora Urban** 7.Card Number:**101800713878** 8.Authorization No: **630129376959**

9.Vote: 10.Preliminary Diagnosis (Code): **No diagnosis entered** 11.Final Diagnosis (Code): **M54.5**

B: Details / Cost of services

Description	Item Code	Qty	Unit Price	Amount
CONSULTATIONS				
Cons_Specialist_new	10002	1	15,000	15,000
SUB TOTAL				15,000
MEDICINES				
Diclofenac Sodium{DYCLO} 75mg/3ml IM Injection	11006	1	1,000	1,000
Diclofenac Sodium{Remethan}}{C} 100mg Tab	11010	6	1,500	9,000
Diclofenac{DOFEC}{A} Gel 20g	11533	1	2,000	2,000
SUB TOTAL				12,000
SUPPLIES/SERVICES				
Syring 5cc	12011	1	130	130
SUB TOTAL				130
GRAND TOTAL				27,130

C: Name of attending clinician: Samwel Mgelwa **Qualifications:** Specialist **MCT Reg. No:** 3148 **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: **Triphonia Biyengo** **Tarehe(Date)** **05-03-2021** **Namba ya Simu(Mobile No.)** **0765292853**

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: Samwel Mgelwa **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)