



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 **01.03.2021**

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:

830129289974

9. Vote: _____

10. Preliminary Diagnosis (Code): **Z32.0**

11. Final Diagnosis (Code):

Z32.0, Z32.0, Z32.1, Z35.1

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				
Urine For Pregnancy Test (UPT)	5244	1	1,500	1,500
PROGESTERONE	5157	1	25,000	25,000
SUB TOTAL				26,500
MEDICINES				
Hyoscine{BISPANOL/Dividol}{A} 10mg Tab	11013	42	400	16,800
Acetylsalicylic Acid{Ascard}{B} 75mg Tab	11428	30	100	3,000
Vitamin B1,B6,B12+Folic Acid (NAT B){C} Cap	12247	30	500	15,000
Dydrogesterone{Duphastone} 10mg Tab	11615	30	2,000	60,000
SUB TOTAL				94,800

GRAND TOTAL	128,300
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C: Name of attending clinician: Titus Pauline

Qualifications: Medical Officer(MD)

MCT Reg. No: 0847

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
	<hr/>		<hr/>		<hr/>

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: Titus Pauline

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)