



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): **C16.1**

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				
H. PYLORI Antigen	5100	1	5,000	5,000
FBP	5091	1	6,000	6,000
mRDT Test	5318	1	2,000	2,000
ENDOSCOPY/OGD	5386	1	100,000	100,000
ABDOMEN SUPINE&ERECT	5288	1	10,000	10,000
SUB TOTAL				123,000

GRAND TOTAL	128,000
-------------	---------

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.

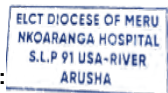
E: Description of In/Out-patient Management/any other additional Information(a separate sheet of paper can be used):.

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)