Form NHIF 2A&B
Regulation 18(1)

CONFIDENTIAL

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 08416\11\2020\46

A:PARTICULARS:

1.Name of Health Facility **MALOLO HOSPITAL** 2.Address **P.O.Box 81 TABORA** 3.Consultation **7,000**

4.Department/Ward **GENERAL CLINIC** 5.Date Of Attendance **02.11.2020** 6.Patient File Number **4385**

7.Name of Patient **Francis Julius** 8.DOB: **1983-12-20** 9.SEX: **m**

10.Vote: 11.Physical Address **Ipuli Tabora Urban** 12.Card Number: **01-11014018**

13.Occupation: 14.Preliminary Diagnosis Code 15.Final Diagnosis Code **M61.9**

B: COST OF SERVICE

Description	Item Code	Qty	Unit Price	Amount
CONSULTATIONS				
Cons_General Practitioner_new	10001	1	7,000	7,000
SUB TOTAL				7,000
INVESTIGATIONS				
X-Ray-Ankle (AP & Lateral)		1	20,000	20,000
SUB TOTAL				20,000
MEDICINES				
Triamcinolone Acetonide{TRIAM}{D} 40mg/ml IM/IA Injectable-	11627	1	3,500	3,500
Ketoprofen{FASTUM / Ketogesic}{S} 2.5% Gel 30g	11538	1	12,000	12,000
Ibuprofen+Paracetamol{Koflame / Intaflam}{A}400/325mg Tab	11016	42	150	6,300
SUB TOTAL				21,800

SUPPLIES/SERVICES				
Syring 2cc	12010	1	130	130
Crepe Bandage 10cm	12023	1	1,950	1,950
SUB TOTAL				2,080
GRAND TOTAL				50,880

C: Name of attending clinician **Mabakila Almasi** Qualification _____ Signature _____

D: Claimant Certification:

I certify that I received the above named services. Name: **Francis Julius** Signature _____

NB: Fill in Triplicate and please submit the original form on monthly basis, and the claim be attached with Monthly Report.

Any falsified information may subject you to prosecution in accordance with NHIF Act No. 8 of 1999.