Form NHIF 2A&B
Regulation 18(1)

CONFIDENTIAL

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 08416\11\2020\1942

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 **21.11.2020** 6.Patient File Number **87**

7.Name of Patient **Honorina Kaombwe** 8.DOB: **1968-03-13** 9.SEX: **f**

10.Vote: 11.Physical Address **Malolo Tabora Urban** 12.Card Number: **01-7754726**

13.Occupation: 14.Preliminary Diagnosis Code 15.Final Diagnosis Code **I10, I10**

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

MEDICINES				
Losartan{LOSARTAS}-INTAS{C} 50mg Tab	11469	30	500	15,000
Bendrofluazide{Benduric}{A} 5mg Tab	11571	30	50	1,500
Atenolol tab{TENBETA}{B} 50mg Tab	11444	30	200	6,000
Clopidogrel{CLAVIX}-INTAS{D} 75mg Tab	11487	30	600	18,000
SUB TOTAL				40,500

GRAND TOTAL	47,500

C: Name of attending clinician **Baptist Matonya** Qualification _____ Signature _____

D: Claimant Certification:

I certify that I received the above named services. Name: **Honorina Kaombwe** 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.