# CONFIDENTIAL

Form NHIF 2A
Regulation 18(1)

# THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 04635\12\2020\4269

**A: PARTICULARS:**

**A1: Health Facility Particulars**

| | | | |
|---|---|---|---|
| 1. Name of Health Facility | **AICC HOSPITAL** | 2.Address | **Aicc Hospital P.O.Box 3081, Arusha** |
| 3.Department | **General Outpatient Clinic** | 4.Date Of Attendance | **30.12.2020** |

**A2: Patient Particulars**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1.Name of Patient | **Shakila Mwekumbi** | 2.DOB: | **22-07-2006** | 3.Sex: | **F** | 4.Occupation: | |
| 5.Patient File No.: | **442342** | 6.Physical Address | **Kaloleni - Urban Ward Arusha** | | | 7.Card Number: | **101102077611** |
| 8.Authorization No: | **921026925094** | 9.Vote: | | | | | |

10.Preliminary Diagnosis (Code): No diagnosis entered **No diagnosis entered**

**B: COST OF SERVICE**

| Description | Item Code | Qty | Unit Price | Amount |
|---|---|---|---|---|
| CONSULTATIONS | | | | |
| Cons_Specialist | 10002 | 1 | 10,000 | 10,000 |
| SUB TOTAL | | | | 10,000 |

| | |
|---|---|
| GRAND TOTAL | 10,000 |

**C: Name of attending clinician:** _____ **Qualifications:** _____ **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:** **Shakila Mwekumbi** **Tarehe(Date)** **30-12-2020** **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):.**

---

**E: Claimant Certification:**

I Certify that I provided the above services.

**Name:** **Signature:**

**Official Stamp:**

SHREE HINDU UNION
CHARITABLE HOSPITAL
P O. Box 3051 ARUSHA
TEL. 250-6389 0754-264874

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.