CONFIDENTIAL

Form NHIF 2A&B
Regulation 18(1)

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 08416\11\2020\131

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 **3960**

7.Name of Patient **Naim Almasi** 8.DOB: **2018-11-03** 9.SEX: **m**

10.Vote: 11.Physical Address **Ipuli Tabora Urban** 12.Card Number: **304201788688**

13.Occupation: 14.Preliminary Diagnosis Code 15.Final Diagnosis Code **No d**

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				
Tramadol{TRADMIN}{B}100mg/2ml IV/IM Injection	11030	1	2,000	2,000
Ibuprofen{IBUMEX/ IBUN}{A} 200mg/5ml Suspension	11015	1	1,950	1,950
SUB TOTAL				3,950

SUPPLIES/SERVICES				
Syring 2cc	12010	1	130	130
SUB TOTAL				130
GRAND TOTAL				11,080

C: Name of attending clinician **Maneno Masunga** Qualification Signature

D: Claimant Certification:

I certify that I received the above named services. Name: **Naim Almasi** 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.