CONFIDENTIAL

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Form NHIF 2A
Regulation 18(1)

Serial No: 08416\02\2021\115

A: PARTICULARS:

A1: Health Facility Particulars

1. Name of Health Facility **MALOLO HOSPITAL** 2.Address **P.O.Box 81 TABORA** 3.Department **GENERAL CLINIC** 4.Date Of Attendance **01.02.2021**

A2: Patient Particulars

1.Name of Patient **Aika Mtenga** 2.DOB: **24-11-2017** 3.Sex: **F** 4.Occupation: 5.Patient File No.: **122**

6.Physical Address **Malolo Tabora Urban** 7.Card Number:**303201411227** 8.Authorization No: **420128193834**

9.Vote: 10.Preliminary Diagnosis (Code): **N39.0** 11.Final Diagnosis (Code): **R10.3, R10.4, K14.0**

B: Details / Cost of services

Description	Item Code	Qty	Unit Price	Amount
CONSULTATIONS				
Cons_General Practitioner_new	10001	1	7,000	7,000
SUB TOTAL				7,000
INVESTIGATIONS				
LEU	5237	1	2,000	2,000
MRDT	5318	1	2,000	2,000
BIL	5237	1	2,000	2,000
SUB TOTAL				6,000
MEDICINES				
Cetirizine{SATRIN}{A} 5mg/5ml Syrup 60ml	11039	1	2,000	2,000
Amoxycillin+Clavulanic Acid{Curam}{B} 625mg Tab	11107	7	1,250	8,750
Cough Mixture{A}{TOTOLYN}Pediatric{3yrs to 12yrs} Syrup	12242	1	2,600	2,600
Paracetamol{Regamol}{A} 500mg Tab	11024	15	20	300
Hydrogen Peroxide{A} 3% Mouth Wash 100ml	11512	1	1,100	1,100
SUB TOTAL				14,750

GRAND TOTAL	27,750

C: Name of attending clinician: Yohana M. Msumba **Qualifications:** Medical Officer(MD) **MCT Reg. No:** 4125 **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: **Aika Mtenga** **Tarehe(Date)** **05-02-2021** **Namba ya Simu(Mobile No.)** **0713443521**

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: Yohana M. Msumba **Signature:**

Official Stamp: ELCT DIOCESE OF MERU NKOARANGA HOSPITAL S.L.P 91 USA-RIVER ARUSHA

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.
.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)