CONFIDENTIAL

Form NHIF 2A&B
Regulation 18(1)

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 08416\11\2020\191

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 **3678**

7.Name of Patient **Shabani Ibrahimu** 8.DOB: **2008-10-28** 9.SEX: **m**

10.Vote: 11.Physical Address **Malolo Tabora Urban** 12.Card Number: **06-11059903**

13.Occupation: 14.Preliminary Diagnosis Code 15.Final Diagnosis Code **A06, J06.9, K59.1**

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				
STOOL ANALYSIS		1	2,000	2,000
SUB TOTAL				2,000
MEDICINES				
Zinc Sulphate{Ped Zinc}{A} 20mg Tablet	11609	10	150	1,500
Ampicillin+Cloxacillin{ZUCLOX}{B} 500mg Cap	11113	15	190	2,850
SUB TOTAL				4,350

GRAND TOTAL	13,350

C: Name of attending clinician **Titus Pauline** Qualification _____ Signature _____

D: Claimant Certification:

I certify that I received the above named services. Name: **Shabani Ibrahimu** 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.