Form NHIF 2A&B
Regulation 18(1)

CONFIDENTIAL

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 08416\11\2020\314

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 **04.11.2020** 6.Patient File Number **3627**

7.Name of Patient **Zitta Tesha** 8.DOB: **1967-05-22** 9.SEX: **f**

10.Vote: 11.Physical Address **Ipuli Tabora Urban** 12.Card Number: **01-8608262**

13.Occupation: 14.Preliminary Diagnosis Code 15.Final Diagnosis Code **D17, J30.4**

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				
Uric Acid		1	5,000	5,000
USS - Small Part (e.g. Scrotum Etc)		1	20,000	20,000
X-Ray Shoulder (AP & Lateral)		1	20,000	20,000
SUB TOTAL				45,000
MEDICINES				
Paracetamol+Chlorzoxazone+Diclofenac{MUSCLE PLUS}{C} 500/250	11011	15	300	4,500
Loratidine{C} 10mg Tab	11047	14	320	4,480
SUB TOTAL				8,980

GRAND TOTAL	60,980

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

D: Claimant Certification:

I certify that I received the above named services. Name: **Zitta Tesha** 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.