CONFIDENTIAL

Form NHIF 2A
Regulation 18(1)

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 04635\01\2021\697

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 **18.01.2021**

A2: Patient Particulars

1.Name of Patient **Mariah Munanka** 2.DOB: **19-03-2019** 3.Sex: **F** 4.Occupation:

5.Patient File No.: **43445453** 6.Physical Address **Piki Wete** 7.Card Number:**101102132946**

8.Authorization No: **310127571852** 9.Vote:

10.Preliminary Diagnosis (Code): **B52** 11.Final Diagnosis (Code): **B53**

B: Details / Cost of services

Description	Item Code	Qty	Unit Price	Amount
CONSULTATIONS				
Specialist Consultation	10002	1	10,000	10,000
SUB TOTAL				10,000
INVESTIGATIONS				
ECG		1	15,000	15,000
CHEST PA		1	10,000	10,000
SUB TOTAL				25,000
MEDICINES				
Paracetamol Tab B/100	11024	9	20	180
SUB TOTAL				180

SUPPLIES/SERVICES				
Catherer three way 22FR each	12039	6	2,600	15,600
Wound Dressing (OutPatient) Stitch removal	6157	1	2,000	2,000
SUB TOTAL				17,600
GRAND TOTAL				52,780

C: Name of attending clinician: israel **Qualifications:** **MCT Reg. No:** 0

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: **Mariah Munanka** **Tarehe(Date)** **18-01-2021** **Namba ya Simu(Mobile No.)**

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.

Signature:

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: israel **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)