Form NHIF 2A
Regulation 18(1)

CONFIDENTIAL

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 04635\01\2021\700

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 **26.01.2021**

A2: Patient Particulars

1.Name of Patient **Shakila Mwekumbi** 2.DOB: **22-07-2006** 3.Sex: **F** 4.Occupation: 5.Patient File No.: **45345555**

6.Physical Address **Ngulilo Ileje** 7.Card Number:**101102077611** 8.Authorization No: **610127938115**

9.Vote: 10.Preliminary Diagnosis (Code): **B53** 11.Final Diagnosis (Code): **P37.4**

B: Details / Cost of services

Description	Item Code	Qty	Unit Price	Amount
CONSULTATIONS				
General Practitioner Consultation	10001	1	5,000	5,000
SUB TOTAL				5,000
INVESTIGATIONS				
ABO grouping		1	6,000	6,000
ABO grouping		1	6,000	6,000
ESR		1	2,000	2,000
CLAVICLE		1	10,000	10,000
SUB TOTAL				24,000
MEDICINES				
Paracetamol Tab B/100	11024	30	20	600
Amoxycillin 250mg Caps B/100	11696	18	80	1,440
SUB TOTAL				2,040

SUPPLIES/SERVICES				
CREEP BANDAGE 6	12023	3	1,950	5,850
SUB TOTAL				5,850
GRAND TOTAL				36,890

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: **Shakila Mwekumbi** **Tarehe(Date)** **26-01-2021** **Namba ya Simu(Mobile No.)** _____

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: 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)