Form NHIF 2A
Regulation 18(1)

CONFIDENTIAL

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 08416\01\2021\1300

A: PARTICULARS:

A1: Health Facility Particulars

1. Name of Health Facility **MALOLO HOSPITAL** 2.Address **P.O.Box 81 TABORA**

3.Department **ORTHOPAEDICS** 4.Date Of Attendance **15.01.2021**

A2: Patient Particulars

1.Name of Patient **Rosemary Bengwa** 2.DOB: **13-12-2000** 3.Sex: **F** 4.Occupation:

5.Patient File No.: **536** 6.Physical Address **Ipuli Tabora Urban** 7.Card Number:**101102390209**

8.Authorization No: **510127470230** 9.Vote:

10.Preliminary Diagnosis (Code): **No Diagnosis entered** 11.Final Diagnosis (Code) **M86, Z47**

B: Details / Cost of services

Description	Item Code	Qty	Unit Price	Amount
CONSULTATIONS				
Cons_Specialist_new	10002	1	15,000	15,000
SUB TOTAL				15,000

MEDICINES				
Ibuprofen{IBUMEX}{A} 200mg Tab	11014	28	50	1,400
Ampicillin+Cloxacillin{MILCLOX}{B} 500mg Cap	11113	28	190	5,320
SUB TOTAL				6,720

GRAND TOTAL	21,720

C: Name of attending clinician: Fikiri Martine **Qualifications:** **MCT Reg. No:**

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: **Rosemary Bengwa** **Tarehe(Date)** **26-01-2021** **Namba ya Simu(Mobile No.)** **0755324351**

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: Fikiri Martine **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)