Form NHIF 2A
Regulation 18(1)

CONFIDENTIAL

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 04635\12\2020\4268

A:PARTICULARS:

1.Name of Health Facility **AICC HOSPITAL** 2.Address **Aicc Hospital P.O.Box 3081, Arusha**

4.Department/Ward **General Outpatient Clinic** 5.Date Of Attendance **29.12.2020** 6.Patient File Number **345353**

7.Name of Patient **Johanes Woisso** 8.DOB: **2015-06-09** 9.SEX: **m**

10.Vote: 11.Physical Address **Sanje Kilombero** 12.Card Number: **101102141078**

13.Occupation: 14.Preliminary Diagnosis Code **B52, J12.0** 15.Final Diagnosis Code **B50**

B: COST OF SERVICE

Description	Item Code	Qty	Unit Price	Amount
CONSULTATIONS				
General Practitioner Consultation	10001	1	5,000	5,000
SUB TOTAL				5,000
INVESTIGATIONS				
CBC		1	6,000	6,000
ESR		1	2,000	2,000
ABDOMEN SUPINE&ERECT		1	10,000	10,000
SUB TOTAL				18,000
MEDICINES				
Paracetamol Tab B/100	11024	12	20	240
Ibuprofen100mg & paracetamol 125mg suspension	12056	2	2,500	5,000
Amoxycillin 250mg Caps B/100	11696	6	80	480
SUB TOTAL				5,720

SUPPLIES/SERVICES				
Catherer three way 22FR each	12039	2	2,600	5,200
SUB TOTAL				5,200
GRAND TOTAL				33,920

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: **Johanes Woisso** **Tarehe(Date)** **29-12-2020** **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):.

E: Claimant Certification:

I Certify that I provided the above services.

Name: israel **Signature:**

Official Stamp: MEDICAL OFFICER AICC HOSPITAL ARUSHA - TANZANIA

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.