CONFIDENTIAL

Form NHIF 2A&B
Regulation 18(1)

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 08416\11\2020\186

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 **02.11.2020** 6.Patient File Number **5561**

7.Name of Patient **Shellah Makunga** 8.DOB: **1992-10-27** 9.SEX: **f**

10.Vote: 11.Physical Address **Malolo Tabora Urban** 12.Card Number: **04-10033898**

13.Occupation: 14.Preliminary Diagnosis Code 15.Final Diagnosis Code **A09**

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				
BIL		1	2,000	2,000
STOOL ANALYSIS		1	2,000	2,000
MRDT		1	2,000	2,000
SUB TOTAL				6,000
MEDICINES				
Ringers Lactate {RL} Infusion{A} 500ml	11372	5	1,300	6,500
Ondansetron{S} 8mg/4ml IV Injection	11306	1	4,000	4,000
Ondansetron{S} 8mg/4ml IV Injection	11306	1	4,000	4,000
Azithromycin{AZIKO}{A} 500mg Cap	12074	7	1,600	11,200
Ibuprofen{IBUMEX}{A} 200mg Tab	11014	18	50	900
SUB TOTAL				26,600

SUPPLIES/SERVICES				
I.V Giving Set{Neo Vac}	12014	1	650	650
Cannula 18G{Green}	12038	1	1,040	1,040
SUB TOTAL				1,690
GRAND TOTAL				41,290

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

D: Claimant Certification:

I certify that I received the above named services. Name: **Shellah Makunga** 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.