Form NHIF 2A&B
Regulation 18(1)

CONFIDENTIAL

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 00002\10\2020\2203

A:PARTICULARS:

1.Name of Health Facility **MALOLO HOSPITAL** 2.Address **P.O.Box 81 TABORA** 3.Consultation **15,000**

4.Department/Ward **ORTHOPAEDICS** 5.Date Of Attendance **19.10.2020** 6.Patient File Number **22**

7.Name of Patient **Pilli Petro** 8.DOB: **1983-12-12** 9.SEX: **f**

10.Vote: 11.Physical Address **Malolo Tabora Urban** 12.Card Number: **02-10741841**

13.Occupation: 14.Preliminary Diagnosis Code 15.Final Diagnosis Code **M13.0, M06.9, M10**

B: COST OF SERVICE

Description	Item Code	Qty	Unit Price	Amount
CONSULTATIONS				
Consultation Specialist	0	1	15,000	15,000
SUB TOTAL				15,000
INVESTIGATIONS				
Uric Acid		1	5,000	5,000
RHEUMATOID FACTOR		1	5,000	5,000
SUB TOTAL				10,000
MEDICINES				
Prednisolone{PREDNIKANT}{B} 5mg Tab	11622	30	50	1,500
Meloxicam{M-Cam}{C} 15mg Tab	11021	30	300	9,000
SUB TOTAL				10,500

GRAND TOTAL	35,500

C: Name of attending clinician **Fikiri Martine** Qualification _____ Signature _____

D: Claimant Certification:

I certify that I received the above named services. Name: **Pilli Petro** 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.