Form NHIF 2A&B
Regulation 18(1)

CONFIDENTIAL

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 08416\11\2020\19

A:PARTICULARS:

1.Name of Health Facility **MALOLO HOSPITAL** 2.Address **P.O.Box 81 TABORA** 3.Consultation **7,000**

4.Department/Ward **Maternity Ward** 5.Date Of Attendance **01.11.2020** 6.Patient File Number **25232**

7.Name of Patient **Sarah Titus** 8.DOB: **1985-11-14** 9.SEX: **f**

10.Vote: 11.Physical Address **Ipuli Tabora Urban** 12.Card Number: **203400471460**

13.Occupation: 14.Preliminary Diagnosis Code 15.Final Diagnosis Code **Z34.9, R10, B37.3**

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

GRAND TOTAL	7,000

C: Name of attending clinician **Shija F Luswetula** Qualification _____ Signature _____

D: Claimant Certification:

I certify that I received the above named services. Name: **Sarah Titus** 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.