CONFIDENTIAL

Form NHIF 2A&B
Regulation 18(1)

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 08416\11\2020\163

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 **3710**

7.Name of Patient **Bavuga Kigali** 8.DOB: **1964-07-01** 9.SEX: **m**

10.Vote: 11.Physical Address **Kaliua Urambo** 12.Card Number: **01-9048553**

13.Occupation: 14.Preliminary Diagnosis Code 15.Final Diagnosis Code **No d**

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				
BLOOD UREA		1	5,000	5,000
Serum Blood Creatinine		1	5,000	5,000
TOTAL PROTEIN		1	5,000	5,000
SUB TOTAL				15,000
MEDICINES				
Ampicillin+Cloxacillin{ZUCLOX}{B} 500mg Cap	11113	15	190	2,850
Amlodipine(Novartis){C} 10mg Tab	11439	30	350	10,500
SUB TOTAL				13,350

GRAND TOTAL	35,350

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

D: Claimant Certification:

I certify that I received the above named services. Name: **Bavuga Kigali** 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.