Form NHIF 2A&B
Regulation 18(1)

CONFIDENTIAL

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 08416\10\2020\3567

A:PARTICULARS:

1.Name of Health Facility **MALOLO HOSPITAL** 2.Address **P.O.Box 81 TABORA** 3.Consultation **0**

4.Department/Ward **GENERAL CLINIC** 5.Date Of Attendance **31.10.2020** 6.Patient File Number **1215**

7.Name of Patient **Shani Mangesho** 8.DOB: **1968-07-01** 9.SEX: **f**

10.Vote: 11.Physical Address **Cheyo Tabora Urban** 12.Card Number: **01-8315207**

13.Occupation: 14.Preliminary Diagnosis Code 15.Final Diagnosis Code **B54, N39.0, M47.8, K27, B54**

B: COST OF SERVICE

Description	Item Code	Qty	Unit Price	Amount
MEDICINES				
Ciprofloxacin{ZINDOLIN/CIPROBID}{A} 500mg Tab	11098	10	200	2,000
SUB TOTAL				2,000

GRAND TOTAL	2,000

C: Name of attending clinician **Neema Missana** Qualification _____ Signature _____

D: Claimant Certification:

I certify that I received the above named services. Name: **Shani Mangesho** 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.