

**CONFIDENTIAL**Form NHIF 2A&B
Regulation 18(1)**THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM**

Serial No: 08416\11\2020\79

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 **4494**
7.Name of Patient **Rahel Mussa** 8.DOB: **1941-08-29** 9.SEX: **f**
10.Vote: 11.Physical Address **Ichemba Urambo** 12.Card Number: **408800512198**
13.Occupation: 14.Preliminary Diagnosis Code 15.Final Diagnosis Code **I11, G60.3**

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
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C: Name of attending clinician Rahel Bwoki Qualification _____ Signature _____**D: Claimant Certification:**I certify that I received the above named services. Name: Rahel Mussa 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.**