Form NHIF 2A&B
Regulation 18(1)

# CONFIDENTIAL

# THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 08416\11\2020\535

**A:PARTICULARS:**

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

4.Department/Ward **GYNAECOLOGY** 5.Date Of Attendance **06.11.2020** 6.Patient File Number **74**

7.Name of Patient **Katalina John** 8.DOB: **1983-08-22** 9.SEX: **f**

10.Vote: 11.Physical Address **Cheyo Tabora Urban** 12.Card Number: **101700753989**

13.Occupation: 14.Preliminary Diagnosis Code 15.Final Diagnosis Code **O34.2**

**B: COST OF SERVICE**

| Description | Item Code | Qty | Unit Price | Amount |
|---|---|---|---|---|
| CONSULTATIONS | | | | |
| Cons_Specialist_new | 10002 | 1 | 15,000 | 15,000 |
| SUB TOTAL | | | | 15,000 |
| INVESTIGATIONS | | | | |
| HB | | 1 | 2,000 | 2,000 |
| Obstretic U/Sound | | 1 | 20,000 | 20,000 |
| SUB TOTAL | | | | 22,000 |

| | |
|---|---|
| GRAND TOTAL | 37,000 |

C: Name of attending clinician **Samwel Mgelwa** Qualification _____ Signature _____

**D: Claimant Certification:**

I certify that I received the above named services. Name: **Katalina John** 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.**