

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

Serial No: 08416\11\2020\42

A: PARTICULARS:

1.Name of Health Facility **MALOLO HOSPITAL** 2.Address **P.O.Box 81 TABORA** 3.Consultation **15,000**
4.Department/Ward **ORTHOPAEDICS** 5.Date Of Attendance **02.11.2020** 6.Patient File Number **5887**
7.Name of Patient **Mwanaidi Mtemi** 8.DOB: **1987-12-31** 9.SEX: **f**
10.Vote: 11.Physical Address **Nzega Mjini Nzega** 12.Card Number: **101200907417**
13.Occupation: 14.Preliminary Diagnosis Code 15.Final Diagnosis Code **M77.3, M17.0**

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				
X-Ray - Both Knees (AP & Lateral)		1	20,000	20,000
X-Ray - Foot (AP& Lateral)		1	20,000	20,000
SUB TOTAL				40,000
MEDICINES				
Glucosamine Hcl 500mg +Hyaluronic Acid 10mg(S){JOINT LUBE} Ta	11021	30	750	22,500
Mefenamic{MEFLAM}{B} Acid 250mg Caps	11020	30	100	3,000
SUB TOTAL				25,500

GRAND TOTAL	80,500
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C: Name of attending clinician **Fikiri Martine** Qualification _____ Signature _____**D: Claimant Certification:**I certify that I received the above named services. Name: **Mwanaidi Mtemi** 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.**