Form NHIF 2A
Regulation 18(1)

CONFIDENTIAL

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 04635\12\2020\4267

A:PARTICULARS:

1.Name of Health Facility **AICC HOSPITAL** 2.Address **Aicc Hospital P.O.Box 3081, Arusha**

4.Department/Ward **General Outpatient Clinic** 5.Date Of Attendance **29.12.2020** 6.Patient File Number **534545**

7.Name of Patient **Halima Kopwe** 8.DOB: **2011-06-08** 9.SEX: **f**

10.Vote: 11.Physical Address **Themi - Urban Ward Arusha** 12.Card Number: **101102179378**

13.Occupation: 14.Preliminary Diagnosis Code **P37.4** 15.Final Diagnosis Code **B52.0**

B: COST OF SERVICE

Description	Item Code	Qty	Unit Price	Amount
CONSULTATIONS				
General Practitioner Consultation	10001	1	5,000	5,000
SUB TOTAL				5,000
INVESTIGATIONS				
UPT		1	1,500	1,500
Urinalysis		1	2,000	2,000
CHEST PA		1	10,000	10,000
SUB TOTAL				13,500
MEDICINES				
Paracetamol Tab B/100	11024	30	20	600
Amoxycillin 250mg Caps B/100	11696	16	80	1,280
SUB TOTAL				1,880
SUPPLIES/SERVICES				
examination gloves large	12001	3	260	780
Catherer three way 16FR each	12039	1	2,600	2,600
Catherer three way 18FR each	12039	3	2,600	7,800
SUB TOTAL				11,180
GRAND TOTAL				31,560

C: Name of attending clinician: israel **Qualifications:** **MCT Reg. No:** 0

Mob. No: **Signature:**

D: Uthibitisho wa mgonjwa/Patient Certification:

Nathibitisha kuwa nimepokea huduma zilizoanishwa hapo juu na natambua kwamba ni kosa kisheria kukiri kupata matibabu ambayo hayajatolewa.

I certify that I received the above mentioned services as witnessed by my signature hereunder and I understand that it is illegal to provide false testimony.

Jina/Name: **Halima Kopwe** **Tarehe(Date)** **29-12-2020** **Namba ya Simu(Mobile No.)**

Signature:

Hakikisha unasaini fomu baada ya kupatiwa huduma na kupatiwa nakala ya fomu hii iliyojazwa huduma ulizopatiwa.

Make sure you receive a copy of the form you signed.

E: Description of In/Out-patient Management/any other additional Information(a separate sheet of paper can be used):.

E: Claimant Certification:

I Certify that I provided the above services.

Name: israel **Signature:**

Official Stamp: 

Patient should sign the form after completion of service.

Before reffering the patient to another facility. The prescriber should be satisfied for the missing item and its alternative within the facility.

Any falsified information may subject you to prosecution in accordance with NHIF Act Cap 395.