Form NHIF 2A
Regulation 18(1)

CONFIDENTIAL

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 04635\01\2021\150

A: PARTICULARS:

A1: Health Facility Particulars

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

3.Department **OBS/GYNAE** 4.Date Of Attendance **02.01.2021**

A2: Patient Particulars

1.Name of Patient **REGINA LOSHI** 2.DOB: **02-12-1987** 3.Sex: **F** 4.Occupation:

5.Patient File No.: **161043** 6.Physical Address **Moshono - Rural Ward Arumeru** 7.Card Number:**101101433937**

8.Authorization No: **710127002855** 9.Vote:

10.Preliminary Diagnosis (Code): **O48** 11.Final Diagnosis (Code): **O48, Q18.4**

B: Details / Cost of services

Description	Item Code	Qty	Unit Price	Amount
INVESTIGATIONS				
FBP		1	6,000	6,000
RANDOM GLUCOSE		1	2,000	2,000
RANDOM GLUCOSE		1	2,000	2,000
USS-OBSTETRIC		1	15,000	15,000
SUB TOTAL				25,000
MEDICINES				
Metronidazole 200mg Tab B/100	11192	4	40	160
ampicillin 250mg+cloxacillin 250mg (ampiclox)	11113	2	190	380
Paracetamol Tab B/100	11024	2	20	40
Ceftriaxone Injection 1gm	11127	1	2,500	2,500
Metronidazole Injection	11190	2	1,500	3,000
Diclofenac Injection	11006	2	1,000	2,000
Pethidine 100mg B/10	11307	3	1,300	3,900
SUB TOTAL				11,980
PROCEDURES				
CAESARIAN SECTION (C/S)	42017	1	110,000	110,000
SUB TOTAL				110,000
SUPPLIES/SERVICES				
BED GENERAL PER NIGHT	21	3	10,000	30,000
I.V giving set each	12014	1	650	650
i.v cannular G 14 each	12038	1	1,040	1,040
syringe disposable 10cc	12009	2	195	390
syringe disposable 5cc	12011	3	130	390
Ringer Lactate 500ml	11372	3	1,300	3,900
Dextrose+Normal saline 500ml	11370	3	1,300	3,900
SUB TOTAL				40,270
GRAND TOTAL				187,250

C: Name of attending clinician: dr kivuyo **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: **REGINA LOSHI** **Tarehe(Date)** **16-01-2021** **Namba ya Simu(Mobile No.)** **0752078148**

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):.

F: Claimant Certification:

I Certify that I provided the above services.

Name: dr kivuyo **Signature:**

Official Stamp:

ELCT DIOCESE OF MERU
NKOARANGA HOSPITAL
S.L.P 91 USA-RIVER
ARUSHA

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.

.Original form to be submitted to NHIF Offices by the treating Health Facility(Yellow). 1st Copy to be retained by the treating Facility (Pink).

2nd Copy to be given to NHIF beneficiary (Blue)