Form NHIF 2A&B
Regulation 18(1)

CONFIDENTIAL

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 08416\11\2020\134

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 **02.11.2020** 6.Patient File Number **6731**

7.Name of Patient **Imelda Sichone** 8.DOB: **1991-03-14** 9.SEX: **f**

10.Vote: 11.Physical Address **Chemchem Tabora Urban** 12.Card Number: **204800749464**

13.Occupation: 14.Preliminary Diagnosis Code 15.Final Diagnosis Code **O20.0**

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				
USS - Obstetric		1	20,000	20,000
SUB TOTAL				20,000

GRAND TOTAL	35,000

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

D: Claimant Certification:

I certify that I received the above named services. Name: **Imelda Sichone** 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.