Form NHIF 2A
Regulation 18(1)

CONFIDENTIAL

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 08416\01\2021\1407

A: PARTICULARS:

A1: Health Facility Particulars

1. Name of Health Facility **MALOLO HOSPITAL** 2.Address **P.O.Box 81 TABORA** 3.Department **GENERAL CLINIC** 4.Date Of Attendance **16.01.2021**

A2: Patient Particulars

1.Name of Patient **Loyce Matata** 2.DOB: **04-06-1989** 3.Sex: **F** 4.Occupation: 5.Patient File No.: **36**

6.Physical Address **Igunga Igunga** 7.Card Number:**101201209473** 8.Authorization No: **810127512025**

9.Vote: 10.Preliminary Diagnosis (Code): **K27, T78.4** 11.Final Diagnosis (Code): **T78.4, K30**

B: Details / Cost of services

Description	Item Code	Qty	Unit Price	Amount
CONSULTATIONS				
Cons_General Practitioner_new	10001	1	7,000	7,000
SUB TOTAL				7,000
INVESTIGATIONS				
H-PYLORY STOOL	5100	1	10,000	10,000
SUB TOTAL				10,000
MEDICINES				
Loratidine{Lorhistina / Loratyn}{C} 10mg Tab	11047	10	320	3,200
Lansoprazole{LAN}-INTAS{C} 30mg Cap	11581	14	325	4,550
SUB TOTAL				7,750

GRAND TOTAL	24,750

C: Name of attending clinician: Rahel Bwoki **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: **Loyce Matata** **Tarehe(Date)** **30-01-2021** **Namba ya Simu(Mobile No.)** **0786465096**

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: Rahel Bwoki **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.
.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)