Form NHIF 2A
Regulation 18(1)

CONFIDENTIAL

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 04635\01\2021\113

A: PARTICULARS:

A1: Health Facility Particulars

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

3.Department **WING B** 4.Date Of Attendance **02.01.2021**

A2: Patient Particulars

1.Name of Patient **ELISARIA SARO** 2.DOB: **10-07-1958** 3.Sex: **F** 4.Occupation:

5.Patient File No.: **94736** 6.Physical Address **Kati - Urban Ward Arusha** 7.Card Number:**106900338201**

8.Authorization No: **410126997634** 9.Vote:

10.Preliminary Diagnosis (Code): **E11** 11.Final Diagnosis (Code): **R34**

B: Details / Cost of services

Description	Item Code	Qty	Unit Price	Amount
CONSULTATIONS				
cons_GENERAL PRACTITIONER	10001	1	5,000	5,000
SUB TOTAL				5,000
INVESTIGATIONS				
FBP		1	6,000	6,000
RANDOM GLUCOSE		1	2,000	2,000
RANDOM GLUCOSE		1	2,000	2,000
BLOOD UREA		1	5,000	5,000
CREATININE		1	5,000	5,000
Urinalysis		1	2,000	2,000
FASTING GLUCOSE		1	2,000	2,000
CHEST PA		1	10,000	10,000
SUB TOTAL				34,000
MEDICINES				
Metronidazole Injection	11190	3	1,500	4,500
Furosemide Injection	11573	3	750	2,250
Furosemide Injection	11573	12	750	9,000
Ceftriaxone Injection 1gm	11127	6	2,500	15,000
SUB TOTAL				30,750

GRAND TOTAL	69,750

C: Name of attending clinician: DR.LOVENESS MAKUNGU **Qualifications:** Medical Officer(MD) **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: **ELISARIA SARO** **Tarehe(Date)** **16-01-2021** **Namba ya Simu(Mobile No.)** **0785230305**

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.LOVENESS MAKUNGU **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)