Form NHIF 2A&B
Regulation 18(1)

# CONFIDENTIAL

# THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 08416\10\2020\3575

**A:PARTICULARS:**

1.Name of Health Facility **MALOLO HOSPITAL** 2.Address **P.O.Box 81 TABORA** 3.Consultation **0**

4.Department/Ward **GENERAL CLINIC** 5.Date Of Attendance **31.10.2020** 6.Patient File Number **2903**

7.Name of Patient **Jenifa Donongo** 8.DOB: **1993-07-16** 9.SEX: **f**

10.Vote: 11.Physical Address **Malolo Tabora Urban** 12.Card Number: **101501906634**

13.Occupation: 14.Preliminary Diagnosis Code 15.Final Diagnosis Code **B37.3, R10**

**B: COST OF SERVICE**

| Description | Item Code | Qty | Unit Price | Amount |
|---|---|---|---|---|
| MEDICINES | | | | |
| Ibuprofen+Paracetamol{Koflame / Intaflam}{A}400/325mg Tab | 11016 | 9 | 150 | 1,350 |
| Clotrimazole{VAGID}{A} Vaginal Pessaries P/6 | 11496 | 1 | 2,500 | 2,500 |
| SUB TOTAL | | | | 3,850 |

| | |
|---|---|
| GRAND TOTAL | 3,850 |

C: Name of attending clinician **Titus Pauline** Qualification _____ Signature _____

**D: Claimant Certification:**

I certify that I received the above named services. Name: **Jenifa Donongo** 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.**