Form NHIF 2A&B
Regulation 18(1)

CONFIDENTIAL

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 08416\10\2020\3537

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 **3705**

7.Name of Patient **Jumanne Katoto** 8.DOB: **1953-07-01** 9.SEX: **m**

10.Vote: 11.Physical Address **Urambo Urambo** 12.Card Number: **107800242972**

13.Occupation: 14.Preliminary Diagnosis Code 15.Final Diagnosis Code **I10, B35.4**

B: COST OF SERVICE

Description	Item Code	Qty	Unit Price	Amount
MEDICINES				
Fluconazole{FLUDERM}{A} 150mg Tab	11175	14	900	12,600
SUB TOTAL				12,600

GRAND TOTAL	12,600

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

D: Claimant Certification:

I certify that I received the above named services. Name: **Jumanne Katoto** 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.