Form NHIF 2A
Regulation 18(1)

CONFIDENTIAL

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Serial No: 04635\01\2021\202

A: PARTICULARS:

A1: Health Facility Particulars

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

3.Department **General Outpatient Clinic** 4.Date Of Attendance **03.01.2021**

A2: Patient Particulars

1.Name of Patient **EDWIN KITEMBE** 2.DOB: **11-12-1963** 3.Sex: **M** 4.Occupation:

5.Patient File No.: **1162** 6.Physical Address **Kati - Urban Ward Arusha** 7.Card Number:**01-AICC560**

8.Authorization No: **110127010364** 9.Vote:

10.Preliminary Diagnosis (Code): **10.Final Diagnosis (Code)** **E10**

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

MEDICINES				
Amlodipine 10mg Tab B/30	11439	30	350	10,500
Losartan 50mg+Hydrochlorothiazide 12.5mg	11463	30	750	22,500
Acetylsalicylic acid 75mg	11428	30	100	3,000
Metformin 500mg +glimipiride 2mg (ilet b2)	11647	60	1,000	60,000
SUB TOTAL				96,000

GRAND TOTAL	101,000

C: Name of attending clinician: DR KAVISHE **Qualifications:** Assistant Medical Officer(AMO) **MCT Reg. No:** 2537

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: **EDWIN KITEMBE** **Tarehe(Date)** **16-01-2021** **Namba ya Simu(Mobile No.)** **0756012222**

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.

Signature:

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 KAVISHE **Signature:**

Official Stamp: ELCT DIOCESE OF MERU NKOARANGA HOSPITAL S.L.P 91 USA-RIVER ARUSHA

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)