



# JOCHAM HOSPITAL

AT JUNCTION OF NEW AND OLD MALINDI RD-KENGELENI

P. O BOX 88984 MOMBASA

TEL Nos. :474472/4,0208017612,0722207664

Email :info@jochamhospital.org

## FINAL INVOICE

**Patient** 00098958  
ABIGAIL MUNGAI KIOKO  
P.O. Box -  
0712781932

**MCC No.:**

**Policy No. :**

**Paying by :**

**Payer** Account:D0089  
UAP INSURANCE COMPANY LTD  
P.O. Box 43013 - 0100-NAIROBI

**Inv. Date....:** 20/06/2021  
**Inv. No. ....:** S210601883  
**Staff Ref. ...:** 02151519  
**Next of Kin** KAMENE IRENE  
**Age.....:** 4  
**Disease Codes:**

**Attending Doctor(s):-**  
**A/c. Name**

**Credit/Smart Ref**S210601883

**Balance**

Date	Description of Services	Ref.	Amount	Balance
20/06/2021	CONSULTATION	S210601883	800.00	800.00
20/06/2021	LABORATORY	2106000876	1,320.00	2,120.00
20/06/2021	PHA-S00272-PHARMACY	P210603120	402.00	2,522.00
20/06/2021	PHA-S00034-PHARMACY	P210603120	267.00	2,789.00
20/06/2021	PHA-S00037-PHARMACY	P210603120	173.00	2,962.00
20/06/2021	PRESCRIPTION FEE	P210603120	50.00	3,012.00
			<b>Invoice Amount</b>	<b>3,012.00</b>



**E&OE**

Name.....: \_\_\_\_\_

Signature: \_\_\_\_\_

Date.....: 20/06/2021



# JOCHAM HOSPITAL

P. O. Box P. O BOX 88984 MOMBASA  
Tel. 474472/4, 0208017612, 0722207664  
info@jochamhospital.org

## CONSULTATION DEBIT

Patient:-

No. ...:00098958

Name...:ABIGAIL MUNGAI KIOKO

Account:-

No. ...:D0089

Name...:UAP INSURANCE COMPANY LTD

Ref. No. : S210601883

CONS

CONSULTATION

Credit Slip No.:S210601883

Date.....:20/06/2021

800.00

Total Due.....: 800.00

Paid.....: 0.00

Net Due.....: 800.00

I confirm that I have received the above services.

Name.....: IRENE KAMUKU

Signature: [Signature]

Date.....: 20/06/2021

Processed By: MAWEU

Outpatients



# JOCHAM HOSPITAL

P. O. Box P. O BOX 88984 MOMBASA  
Tel. 474472/4, 0208017612, 0722207664

info@jochamhospital.org

P H A R M A C Y D E B I T

Patient:-

No. ...:00098958

Name...:ABIGAIL MUNGAI KIOKO

Credit Slip No.:S210601883

Account:-

No. ...:D0089

Name...:UAP INSURANCE COMPANY LTD

Date.....:20/06/2021

Location : PHA

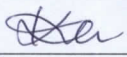
Name...:PHARMACY

Ref. No. ....: P210603120

Item Code	Description	Qty	Selling Price	Total
S00272	SYR CLAVAM BD 228.5MG (AMOXICLA	1	402.00	402.00
S00034	CEZINE 60ML -CETRIZINE	1	267.00	267.00
S00037	DELAED PAEDS 100ML (COUGH SYR	1	173.00	173.00
	Prescription Fee:	50.00	Total Due.....:	892.00
			Paid.....:	0.00
			Net Due.....:	892.00

I confirm that I have received the above services.

Name.....: IRENE KAMENE

Signature: 

Date.....: 20/06/2021

Processed By: REBECCA

Pharmacy



P A T H O L O G Y   D E B I T

Patient:-

No. ...: 00098958

Name..ABIGAIL MUNGAI KIOKO

Account:-

No. ...: D0089

Name..UAP INSURANCE COMPANY LTD

Credit Slip No.: S210601883

Ref. No. ....2106000876

Date.....: 20/06/2021

LB0081      FULL    HAEMOGRAM

1

1,320.00

Total Due.....:

1,320.00

Paid.....:

0.00

Net Due.....:

1,320.00

I confirm that I have received the above services.

Name.....: IRGAC KAMENC

Signature: *IRGAC*

Date.....: 20/06/2021

Processed By: MKALA

Pathology







## SMART BILLING UTILITY REPORT

Service Provider: JOCHAM HOSPITAL  
Account Name: UAP INSURANCE COMPANY LTD  
Satellite Clinic: JOCHAM HOSPITAL

SKSP\_116  
20-Jun-2021 TO 20-Jun-2021

No.	Billing Date	Account Name	Scheme Name	Benefit Description	Member Number	Patient Name	Patient File No	Invoice No	Claim Type	Amount
1	20/06/2021 10:57:43	UAP INSURANCE COMPANY LTD	FAULU MICROFINANCE BANK LIMITED	OUT PATIENT OVERALL CONSULTATION LABARATORY PATHOLOGY XRAY	02151519-04	ABIGAIL KIOKO	00088958	S210601883	NORMAL CLAIM	800.00
2	20/06/2021 11:26:43	UAP INSURANCE COMPANY LTD	FAULU MICROFINANCE BANK LIMITED	OUT PATIENT OVERALL CONSULTATION LABARATORY PATHOLOGY XRAY	02151519-04	ABIGAIL KIOKO	00088958	S210601883	NORMAL CLAIM	1,320.00
3	20/06/2021 12:17:16	UAP INSURANCE COMPANY LTD	FAULU MICROFINANCE BANK LIMITED	OUT PATIENT OVERALL CONSULTATION LABARATORY PATHOLOGY XRAY	02151519-04	ABIGAIL KIOKO	00088958	S210601883	NORMAL CLAIM	892.00
Grand Total: KShs 3,012.00										

MEDICAL SERVICE PROVIDER:		PAYER/SCHEME ADMINISTRATOR:	
SENT BY:		APPROVED BY:	
SIGNATURE/STAMP:		DESIGNATION:	
DATE:		DATE:	





OLDMUTUAL

# OUT-PATIENT CLAIM FORM

Practitioners Name \_\_\_\_\_

Practitioner's Official Stamp

Postal Address \_\_\_\_\_

Tel No. \_\_\_\_\_ Mobile \_\_\_\_\_

Email \_\_\_\_\_

## PATIENT'S PARTICULARS

Full Name of Patient ABIGAIL MUNGA KIKO Date of Birth 2017

Full Name of Member (if patient is a dependant) URBANUS KIKO MWANIA

Member's Tel No. 0724 854 483 Member No. 02 N 151904

Member's Employer Name FAHLL MICRO-FINANCE Dept./Branch MOI - AVENUE

Have you suffered from this sickness in the past? ☒ YES ☐ NO

If YES, when did it start and how frequent is it? N/A

## CONSULTATION/REFERRALS

DIAGNOSIS: URTI - flu + cough; fever

## TREATMENT PRESCRIBED

<b>MEDICINES:</b>	Prescription <input type="checkbox"/>	Injection given <input type="checkbox"/>	Dispensed <input type="checkbox"/>
<b>RADIOLOGY:</b>	X-Ray <input type="checkbox"/>	MRI/Cat Scan <input type="checkbox"/>	Other <input type="checkbox"/>
<b>PATHOLOGY:</b>	Haematology <input checked="" type="checkbox"/>	Microbiology <input type="checkbox"/>	Biochemistry <input type="checkbox"/>

Hospital Name: \_\_\_\_\_ Consultant Referred To: \_\_\_\_\_ Specialty: \_\_\_\_\_

## MEDICATION PRESCRIBED:

@ Antibiotics  
@ Analgesics  
Dr. Shabazz

Dr's Signature \_\_\_\_\_ Date 20/6/21

## DECLARATION

I warrant the truth of the above statements. I have not withheld or misstated material information relating to this claim and have no objection to yourselves communicating with my medical doctor with regard to this claim.

Member's Signature [Signature] Date 20/6/21

UAP Insurance Company Limited

UAP Old Mutual Tower, Upperhill Road. P.O Box 43013-00100 Nairobi, Tel: +254 711 065 100 / +254 20 285 0000  
Email: uapoutpatient@uapoldmutual.com Website: www.uapoldmutual.com