DR MARX MANASSEH O OKONJI FRC Psych.
MB. ChB(NBI) DPM (LONDON)
MRC Psych (U.K.)

Nairobi Hospital
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1st Floor
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P.O. Box 50468-00200
NAIROBI,KENYA
Cell: 0715 216 242
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docrees@gmail.com

INVOICE

Date 16.11.23

To Medical Claims
Olal Muhol

DR. M. M. O. OKONJI FRC Psych.
MB. ChB(NBI) MRC Psych (U.K.) DPM (LONDON)

OA144388-00

Accounts For Professional Services

Rendered to
Mr./Mrs./ Miss Nancy Narotso Mwakio

CONSULTATIONS OPV 16.11.23 @ 3000

HOSPITAL/HOME VISITS

DOCTOR'S FEE Ksh 3000

Prescription / Injections / Drugs

Others

NO. 27820

TOTAL Ksh 3000

(cheques payable to **Dr Marx Manasseh O. Okonji**)

OLDMUTUAL

OUT-PATIENT CLAIM FORM

OLD MUTUAL GENERAL INSURANCE KENYA LIMITED
Old Mutual Tower, Upper Hill Road, PO Box 43013 - 00100, Nairobi, Kenya
Tel +254 (0) 711 065 100, +254 (20) 2850 000, Email omoutpatient@oldmutual.co.ke
www.oldmutual.co.ke

Practitioners Name _____

Postal Address _____

Tel No. _____ Mobile _____

Email _____

Practitioner's Official Stamp

DR. M. M. O. OKONJI FRC Psych.
MB. ChB(NBI) MRC Psych (U.K.) DPM (LONDON)

PATIENT'S PARTICULARS

Full Name of Patient NANCY NAROTSO MWAKHA Date of Birth 16.11.79

Full Name of Member (if patient is a dependant) SELF

Member's Tel No. 0710400211 Member No. OA/44888-00

Member's Employer Name CHURCH WORLD SERVICE & WITNESS Dept. /Branch RDP

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

If YES, when did it start and how frequent is it? _____

CONSULTATION/REFERRALS

DIAGNOSIS: Affective Disorder

TREATMENT PRESCRIBED

MEDICINES:	Prescription		Injection given		Dispensed		None	
RADIOLOGY:	X-Ray		MRI/Cat Scan		Other		Other	
PATHOLOGY:	Haemotology		Microbiology		Biochemistry		Histology	

Hospital Name: _____ Consultant Referred To: _____ Specialty: _____

MEDICATION PRESCRIBED:

Tab Sodium Valproate

Dr's Signature _____ **Date** 16/11/2023.

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 _____ **Date** 16.11.23