NHIF CONFIDENTIAL
HEALTH PROVIDER IN / OUT PATIENT CLAIM FORM

Form 2A&B
Regulation 18(1)

Folio No: 3 Bill No: 69 Serial no:04299/10/2021/3

A. PARTICULAR

1. Name : Bugando Medical Centre
2. Accreditation No :
3. Address : 1370
4. Patient Name : Elieshi S Ogutu
5. Age : 78 Years, 2 Months, 0 Days
6 .Sex : Female
7. Membership No : 04-8898599
8. Occupation : ASKARI
9. Date of attendance : 2021-10-01
10.Preliminary Diagnosis(Code): E11.4;
11. Final Diagnosis(Code): M54.2; E11.4; I11.; E78.5; R25.2; E56;
12. Patient Status: OUT
13. Patient's Vote No: 28
14. Authorization No: 101127570618

B. COST OF SERVICES :

Registration/Consultation Charges

SN	Codes	Item Description	Receipt No	Price	Quantity	Discount	Amount
1	10002	**Specialist Consultation**	4527268	25,000	1	0	25,000
							Sub Total : 25,000

Medicine

SN	Codes	Item Description	Receipt No	Price	Quantity	Discount	Amount
1	11304	**Amitriptyline-Hydrochloride 25mg :Dosage(nocte 1/12)**	4527553	150	30	0	4,500
2	11473	**Nifedipine Retard 20mg :Dosage(bd 1/12)**	4527553	190	60	0	11,400
3	12192	**Carvedilol Solid oral dosage form: 6.25mg, :Dosage(bd 1/12)**	4527553	250	60	0	15,000
4	11003	**Aceclofenac 100mg :Dosage(bd 2/52 prn)**	4527553	350	28	0	9,800
5	12203	**Glimeperide Solid Oral dosage form: 2mg :Dosage(od 1/12)**	4527553	350	30	0	10,500
6	11469	**Losartan Potassium/Tozaar 50mg :Dosage(od 1/12)**	4527553	500	30	0	15,000
7	12247	**vitamin B1,B6,B12,Folic acid Solid Oral dosage form~Nat B :Dosage(od 1/12)**	4527553	500	30	0	15,000
8	11584	**Pantoprozole 40mg :Dosage(od 1/12)**	4527553	650	30	0	19,500
9	12211	**Tizanidine hydrochloride Solid oral dosage form: 4mg :Dosage(nocte 1/12)**	4527553	800	30	0	24,000
10	12048	**Glucostic Strips for Sugar Monitoring, each strip(one touch) :Dosage(bd 2/12)**	4527553	850	50	0	42,500
11	11345	**Montelukast Tabs 10MG :Dosage(od 1/12)**	4527553	1,000	30	0	30,000
12	12199	**Rosuvastatin Solid oral dosage form: 20mg :Dosage(nocte 1/12)**	4527553	1,500	30	0	45,000
13	12235	**Sitagliptin(Januvia) Solid oral dosage form:50mg :Dosage(od 1/12)**	4527553	2,000	30	0	60,000
14	11538	**Ketoprofen 30gm :Dosage(bd 1/12)**	4527553	12,000	1	0	12,000
							Sub Total : 314,200

Grand Total : 339,200

C. Name of attending Clinician : Qualifications: Reg No:

Signature:_____ Mob No:

D: Patient Certification

I certify that I received the above named services. Name : **Elieshi S Ogutu** Signature :  Tel

E: Description of Out/In-patient Management / any other additional information

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F: Claimant Certification

I certify that I provided the above services. Name : **BMC System Administ'rator** Signature Official Stamp
NB: Fill in the Triplicate and please submit the original form on monthly basis, and the claim should be attached with Monthly Report.
Any falsified information may subject you to prosecution in accordance.

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