ISO 9001:2015 CERTIFIED

CONTIFIDENTIAL

THE NHIH - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Appendix X

Form NHIF @A & B

Regulation 18(1)

Authorization No:460327856488

Serial No:1405233788

A. PARTICULARS

1.Name Of Health Facility:St.Joseph hospital

2.Address:DAR ES SALAAM-TANZANIA-11007

3.Consultation Fees:5000

4.Department:Out

5.Date Of Attendance:2023-05-12

6.Patient File No:2019/11/MH62547

7.Name Of Patient:HALIMAJUMA

8.DOB:1995-11-07

9.Sex M/F:F

10.Vote:26

11.Patient Physical Address:DAR ES SALAAM-TANZANIA-11007

12.Card No:203801301050

13.Occupation:NONE

14.Preliminary Diagnosis (Code):084

15.Final Diagnosis(Code):084

B. COSTS OF SERVICES

Description	Item Code	Qty	Unit Price	Amount
Consultation				
General Practitioner Consultation	10001	1.0	5000	5000
SUB TOTAL				5000
Medicine				
Ceftriaxone(Rocephine)	11140	1	13300	13300
Prazosin	12224	1	800	800
General Practitioner Consultation	10001	2	50000	100000
Baby Urine Collector	355665	1	3500	3500
X-Ray abdomen - KUB	5287	1	30000	30000
General Practitioner Consultation	10001	1	5000	5000
Baby Urine Collector	355665	1	3500	3500
SUB TOTAL				156100

GRAND TOTAL	161100

C.Name of attending Clinician:DR.NSUBILI ANGETILE MWANSULE Qualification:MD Reg.No:12548 Signature:

D.Patient Certifiction:

I certify that I received the above named services. Name:HALIMAJUMA Mob No:0754272716 Signature:

E.Descriptionof Out/In-patient Management/Any other additional information:

F.Claimant Certification:

I certify that I provide the above names services. Name:Mrs. Judith Signature:

Patient should sign the form after completion of service
Before referring patient to other facility, referring facility should be satisfied for the missing item and its alternative within the facility.
Any falsified information may subject you to prosecutionin accordancewith NHIF Act No.8 of 1999.