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:

Serial No:0501239692

A. PARTICULARS

1.Name Of Health Facility:St.Joseph hospital

2.Address:DAR ES SALAAM-TANZANIA-11007

3.Consultation Fees:

4.Department:Out

5.Date Of Attendance:2022-05-09

6.Patient File No:2022/04/MH76015

7.Name Of Patient:OTIENOBONDO

8.DOB:1997-03-31

9.Sex M/F:M

10.Vote:

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

12.Card No:04-12198410

13.Occupation:FATHER

14.Preliminary Diagnosis (Code):

15.Final Diagnosis(Code):

B. COSTS OF SERVICES

Description	Item Code	Qty	Unit Price	Amount
Consultation				
SUB TOTAL				**0**
Medicine				
ICU Service Charges	**22**	**1**	**700000**	**700000**
HDU Service Charges	**23**	**1**	**200000**	**200000**
ICU Service Charges	**22**	**1**	**700000**	**700000**
HDU Service Charges	**23**	**1**	**200000**	**200000**
ICU Service Charges	**22**	**1**	**700000**	**700000**
HDU Service Charges	**23**	**1**	**200000**	**200000**
SUB TOTAL				**2700000**
GRAND TOTAL				**2700000**

C.Name of attending Clinician: Qualification: Reg.No: Signature: Mob No:

D.Patient Certifiction:

I certify that I received the above named services. Name:OTIENOBONDO Mob No:0747265104 Signature:

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

F.Claimant Certification:

I certify that I provide the above names services. Name: 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.