



CONFIDENTIAL

THE NHIH - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Appendix X

Form NHIF @A & B

Regulation 18(1)

Authorization No:

Serial No:050123484

A. PARTICULARS

1.Name Of Health Facility:St.Joseph hospital

2.Address:DAR ES SALAAM-TANZANIA-NONE

3.Consultation Fees:

4.Department:Out

5.Date Of Attendance:2019-11-03

6.Patient File No:2017/04/MH40878

7.Name Of Patient:GRACIOUSMSANYA

8.DOB:2013-12-14

9.Sex M/F:F

10.Vote:7002124

11.Patient Physical Address:DAR ES SALAAM-TANZANIA-NONE

12.Card No:04-12198410

13.Occupation:CHILDREN

14.Preliminary Diagnosis (Code):

15.Final Diagnosis(Code):

B. COSTS OF SERVICES

Description	Item Code	Qty	Unit Price	Amount
Consultation				
SUB TOTAL				0
Medicine				
HDU Service Charges	23	2	200000	400000
Asomex(S-Amlodipine)	300372	2	800	1600
SUB TOTAL				401600
GRAND TOTAL				401600

C.Name of attending Clinician:

Qualification:

Reg.No:

Signature:

Mob No:

D.Patient Certification:

I certify that I received the above named services.

Name:GRACIOUSMSANYA

Mob No:0713366999

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.