



CONFIDENTIAL

THE NHIF - HEALTH PROVIDER IN/OUT PATIENT CLAIM FORM

Appendix X

Form NHIF @A & B

Regulation 18(1)

Authorization No:07188245862

Serial No:1305234300

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

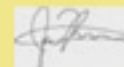
Description	Item Code	Qty	Unit Price	Amount
Consultation				
General Practitioner Consultation	10001	1.0	5000	5000
SUB TOTAL				5000
Medicine				
Prenatal Capsule	355596	1	60000	60000
Oracure (Lidocaine hcl 20mg + Cetylpyridinium chloride 1mg)	356151	1	12500	12500
Ceftriaxone(Rocephine)	300472	1	13300	13300
Prazosin	12224	1	800	800
SUB TOTAL				86600
GRAND TOTAL				91600

C.Name of attending Clinician:DR.NSUBILI ANGETILE MWANSULE

Qualification:MD

Reg.No:12548

Signature:



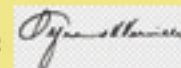
D.Patient Certification:

I certify that I received the above named services.

Name:HALIMAJUMA

Mob No:0754272716

Signature:



E.Description of 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 prosecution in accordance with NHIF Act No.8 of 1999.