



CONFIDENTIAL
THE NHIF -HEALTH PROVIDER IN/OUT PATIENT CLAIM

Appendix x
Form NHIF 2a B
Regulation 18(1)
Authorization No: 880120707769

A. PARTICULARS

1.Name of Health facility: **Chaely Polyclinic**

4.Department: **Out**

7.Name of patient: **Jacob B Rugora**

10.Vote: **28**

13.Occupation:

B.COST OF SERVICES

2.Address: **Kishiri Mwanza**

5.Date of attendance: **8/22/2021 03:47:58**

8.DOB: **3/17/2006 00:00:00**

11.Patient physical address: **KISHIRI**

14.Preliminary diagnosis code: **A00.9,A02.2**

Serial No: 09353/08/2021/00005

3.Consultation fee: **15000**

6.Patient file No: **195**

9.Sex M/F: **Male**

12.Card No: **303100461122**

15.Final Diagnosis code: **A00.9,A02.2**

Description	item Code	Qty	Unit Price	Amount
CONSULTATION				
Consultation-Specialist	10002	1	15,000	15,000
			SUB-TOTAL:	15,000
INVESTIGATION				
Advanced detailed Echocardiogram studies - 3D, strain ...	6345	1	100,000	100,000
Ambulance Charges outside Region charge per KM	7431	1	10,000	10,000
			SUB-TOTAL:	110,000
			TOTAL:	125,000

C.Name of attending Clinician: **PROTAZ, JANETH** Qualifications: **med** Reg.No: **2323** Signature: **JP** Mob No: **0754320**

D.Patient Certification:

I certify that I received the above named services :: Name: **Jacob B Rugora** Mob No: Signature:

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

F.Claimant certification:

I certify that I provided the above named services :: Name: **Thadeo Peter** Signature:

Patient should sign the form after completion of the services.

Before referring the patient to other facility, referring facility should be satisfied for the missing items and its alternative within the facility.

Any falsified information may subject you to prosecution accordance with the NHIF Act No. 8 of 1999.