



NATIONAL HOSPITAL INSURANCE FUND

P.O. Box 30443, NAIROBI

Website: www.nhif.or.ke Email: info@nhif.or.ke

GENERAL CLAIM FORM

PART I: CONTRIBUTORS PARTICULARS

1. Surname / Main Name.....
2. Other Names
3. I.D. No..... NHIF Contribution No.....
4. Date when first contribution was due
5. Postal Address
6. Name of Employer.....
7. Address of Employer

PART II: PATIENT PARTICULARS

1. Surname / Main Name
 2. Other Names
 3. Date of Birth
 4. I.D. No. where patient is self or spouse.....
 5. Postal Address of the patient
 6. Patient's relationship to contributor
- (State whether self, wife/husband or child)

PART III: HOSPITAL PARTICULARS

1. Hospital's full name
 2. Hospital's Address.....
 3. NHIF Approved rate Ksh per day
 4. Patient's date of admission
 5. Patient's date of discharge
 6. Nature of treatment
- (State whether medical, surgical, maternity or therapy)
7. Receipt No..... Hospital's statement No.....

I certify that my contribution to the National Hospital Insurance Fund has been paid up to date and I attach my card in evidence. I also certify that to the best of my knowledge and belief that hospitalization in this case does not result from injury or illness in respect of which claim for compensation or damages has been or will be lodged under the Workmen's Compensation Act (Cap. 236).

Date _____

Signature

PART IV: OFFICIAL USE ONLY

- 1. Hospital Code No.....
- 2. Claim No
- 3. Checked by:
 - a. Full Name
 - b. I certify that I examined the card No..... and that it had..... stamps or
franking impressions of contributions paid vide certificated of contribution paid serial No

Date:

.....

Signature

NB:- In terms of section 36 of the National Hospital Insurance Act, no benefits are payable for any treatment resulting from injury or illness where a contributor is entitled to recover compensation or damages under the Workmen's Compensation Act (Cap. 236)