NATIONAL HOSPITAL INSURANCE FUND
P.O. Box 30443 - 00100, NAIROBI
Tel 020 – 2723255/6
Website: www.nhif.or.ke Email: info@nhif.or.ke

REFERRAL FORM FOR OVERSEAS TREATMENT MANAGED SCHEME

Part A: Patient particulars (To be completed by the Principle member)

Name of the Principle Member:	**NHIF No:**	**ID No:**	**Job Group:**
Physical Address:		**Tel. No:**	
Ministry:		**Work Station:**	
County:			
Name of the Patient:	**Age:** **Sex: (Male/Female)**	**Relationship of the Principle Member:** **(Self/Spouse/Dependant)**	

Part B: Details of the illness and planned management (To be completed by referring physician (or equivalent) practicing in a heath facility accredited to NHIF)

Nature of the disease	
How long have you treatment/managed the patient?	
Treatment/Procedure/Investigation for which patient is being referred	
Is the treatment/procedure/investigation option available in Kenya?	
If not, state why the treatment/procedure/investigation outside the country is necessary and essential to the Prognosis of patient's condition.	

Part C: Undertaking By Principle Member

I fully understand the rules governing the medical benefits extended to the Civil Servants and Disciplined Services Principle Members as provided by National Hospital Insurance Fund (NHIF). I undertake to settle the bills pertaining to the treatment imparted by the empanelled medical institution, in the event, I am not eligible to the medical benefit in any way including limits owing to my job group.

SIGNATURE OF THE PRINCIPLE MEMBER: ……

Date: ……..

Part D: Undertaking By Physician In charge

All the above particulars furnished are true/correct. The Principle Member has signed the undertaking before me. The Principle Member is eligible to receive medical benefit under the Civil Servants and Disciplined Services Scheme and NHIF Rules.

Name of the Physician/Specialist …… Reg. No: ……..

Hospital Stamp

SIGNATURE: ……..

Date: ……..