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

(NATIONAL SCHEME)

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

Name of the Principle Member:	**NHIF No:**	**ID No/Passport No:**
Physical Address/Email address: **P.O Box :** **Town:**		**Tel. No:**
Employer (where applicable)		**Job Group(Where applicable)**
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 specialist/Physician (or equivalent)

Nature of the disease	
How long have you treated/managed the patient?	
Treatment/Procedure/Investigation for which patient is being referred:	
Is the treatment/procedure/investigation option available in Kenya?	
If yes, 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 hereby declare that the information given above is true to the best of my knowledge and belief. I fully understand the rules governing the medical benefits extended to the National Scheme Members as provided by National Hospital Insurance Fund(NHIF).

SIGNATURE OF THE PRINCIPLE MEMBER: ……

Date: ……..

Part D: Undertaking By Physician In charge

All the above particulars furnished are true/correct. The Member has signed the undertaking before me.

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

Hospital Stamp

SIGNATURE: ……..

Date: ……
