FORM 3 ((r. 58(4))

Social Health Authority
Bima Bora, Afya Nyumbani

REPUBLIC OF KENYA
SOCIAL HEALTH INSURANCE ACT, 2023
SOCIAL HEALTH INSURANCE (GENERAL) REGULATIONS, 2024

CLAIMS

IMPORTANT CLAIM FILING REMINDERS
1. PLEASE USE CAPITAL LETTERS AND TICK THE APPROPRIATE BOXES.
2. Submit this form with supporting documents within seven (7) days from the discharge date.
3. All fields in this form are mandatory. Incomplete forms will not be processed.
4. Providing false or incorrect information may result in criminal or administrative liabilities.
PLEASE BE AS COMPREHENSIVE AND ACCURATE AS POSSIBLE WHEN COMPLETING THIS CLAIM FORM. ERRORS OR OMISSIONS MAY DELAY CLAIM PAYMENTS
CLAIM NO:
PART I - HEALTH CARE PROVIDERS DETAILS
1. **Health Provider Identification Number:**
2. **Name of Health Care Provider/Facility:**
PART II - PATIENT DETAILS
Patient's Full Name:
• Last Name
• First Name
• Middle Name
3. Social Health Authority Number:
4. Residence:
5. Do you have another Health Insurance:(If Yes, State which one)
6. Relationship to the Principal:
PART III - PATIENT VISIT DETAILS
7.. Referral Information:
Was the patient referred by another Health Care Provider?
• NO
• If, YES
• Name of referring Health Care Provider/Facility:

Visit type: ☐Inpatient ☐Outpatient ☐ Day-care:		
Visit/Admission Date:	OP/IP No.:	New/Return Visit:
Discharge Date:	Rendering Physician Name and Registration No:	
Type of Accommodation:	(*Female Medical, Male Medical, Female Surgical, Male Surgical, Gynaecology, Maternity, NBU, Psychiatric Unit, Burns, ICU, HDU, NICU, Isolation*)	

9. Patient Disposition upon discharge (select only 1):

- Improved ☐
- Recovered ☐
- Leave Against/Discharged Against Medical Advice ☐
- Absconded ☐
- Died ☐

10. Referred (If not referred type N/A)

- Name of Referral Institution:
- Reason/s for referral:

11. Admission Diagnosis/es:

12. Discharge Diagnosis/es:

- Diagnosis:
- ICD-11 Code/s:
- Related Procedure/s (if any):
- Date of Procedure:

14. SHA Health Benefits:

* For outpatient services, Date of service is the Date of admission.

Date of Admission	Date of Discharge	Case Code	ICD 11/ Procedure Code	Description	Preauth No.	Bill Amount	Claim Amount

					Total		

Any unforeseen circumstances or additional information that led to an increased length of stay for this admission? _____

(If the patient is unable to write, please provide necessary information.)

PATIENT'S/ AUTHORISED PERSON'S DECLARATION: I certify that I have received the above treatment, and that the above information is correct. I understand that it is an offence to falsify information to obtain any benefit under the SHI Act 2023.

Names (Majina):_____**Signature(Sahihi):**_____**Date(Tarehe):** _____

E. HOSPITAL DECLARATION: This is to certify that to the best of my knowledge, the information contained above, and any attachments provided is true, accurate, and complete and the service(s) rendered is necessary to the patient's health. I understand that it is an offence to knowingly make any false statement to obtain any benefit under the SHI Act 2023. Please arrange to pay the hospital the sum of Ksh. ..... being the approved amount for services rendered.

Facility stamp

Signature: _____ **Date:** _____

F. FOR OFFICIAL USE ONLY

SHA Receiving

Receiving Officer Name: _____ **Date:** _____

Stamp

Notice: Any person/institution who/ knowingly files a statement of request or claim containing any misrepresentation or false, incomplete, or misleading information may be guilty of medical fraud punishable under law.