Hospital Bill Payment Application Form

Passport Photo

Applicant Name

Local Govt./Village

Type/Place of Work

Next of Kin

NIN Number

Phone number

Gender

Marital Status

Do you have Medical Insurance?	Financial Help for Hospitalization	Hospitalization Date:
		Discharge Date:
Yes ☐	Financial Help for prenatal care	Amount Requested:
No ☐		Amount Approved:

Describe Your Need & Efforts you have made to acquire funds through family, friends and other sources? Include a description of the issues you faced.

Applicant Signature Date

Hospital Administrator Signature Date