TANZANIA INSURANCE REGULATORY AUTHORITY	**MAMLAKA YA USIMAMIZI WA BIMA TANZANIA**
HEALTH INSURANCE CLAIMS PAYMENT GUIDELINES	**MIONGOZO YA ULIPAJI MADAI YA BIMA YA AFYA**
Version No. 1.0 **August, 2025**	**Toleo Na. 1.0** **Agosti, 2025**

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1.1 Authorization and Powers	These guidelines have been issued in accordance with section 7(2)(d) of the Act which mandates the Authority to develop Guidelines on payment of claims for health service providers.	**1.1 Idhini na Mamlaka**	Miongozo hii imetolewa kwa mujibu wa kifungu cha 7(2)(d) cha Sheria ya Bima ya Afya kwa Wote ambacho kinaweka wajibu kwa Mamlaka kutoa Miongozo ya ulipaji wa madai kwa watoa huduma za afya.
1.2 Citation	These Guidelines may be cited as ***"Health Insurance claims payment Guidelines, 2025."***	**1.2 Nukuu**	Miongozo hii itatamkwa kama *"**Miongozo ya ulipaji Madai ya Bima ya Afya, 2025**"*
1.3 Background and Rationale	These Guidelines establish a clear framework for claims payment to ensure timely, appropriate payments, promote trust, ensure compliance, and protect the interests of beneficiaries of health insurance scheme.	**1.3 Usuli na mantiki**	Miongozo hii inaweka mfumo wa malipo ya madai kwa watoa huduma za afya ili kuhakikisha kuwa madai yanalipwa ipasavyo na kwa wakati ili kuwezesha utoaji wa huduma bora na endelevu za matibabu kwa wanufaika wa skimu za bima ya afya.
1.4 Application	1.4.1 These Guidelines shall apply to: - a) Health insurance schemes registered by the Authority; b) Health service providers registered by the Authority to provide health services to beneficiaries of the health insurance schemes; c) Beneficiaries of the health insurance schemes; and	**1.4 Matumizi**	1.4.1 Miongozo hii itatumika kwa: a) Skimu za bima ya afya zilizosajiliwa na Mamlaka; b) Watoa huduma za afya waliosajiliwa na Mamlaka kutoa huduma za afya kwa wanufaika wa skimu za bima ya afya; c) Wanufaika wa skimu za bima ya afya; na d) Mdau mwingine yoyote anayehusika.

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	d) Any other relevant stakeholder.		
1.5 Purpose and Objectives	1. The objectives of these guidelines are to; a) Establish a comprehensive regulatory and supervisory framework for payment of claims by health insurance schemes to health services providers for health services rendered to beneficiaries of health insurance schemes; b) Ensure that all health insurance schemes manage their claims processing and payments efficiently, transparently and in accordance with the set standards; and c) Safeguard the interests of beneficiaries, health service providers and health insurance schemes by ensuring that health insurance services are delivered fairly and genuine claims are paid timely.	**1.5 Malengo na Madhumuni**	Malengo ya miongozo hii ni; a) Kuweka mfumo thabiti wa kisheria na usimamizi kwa ajili ya ulipaji wa madai ya watoa huduma za afya kwa huduma zilizotolewa kwa wanufaika wa skimu za bima ya afya; b) Kuhakikisha skimu za bima za afya zinashughulikia uchakataji na malipo ya madai kwa ufanisi, uwazi na kwa mujibu wa viwango vilivyowekwa; na c) Kulinda maslahi ya wanufaika wa bima ya afya, watoa huduma za afya na skimu za bima ya afya kwa kuhakikisha kuwa huduma za bima ya afya zinatolewa kwa usawa na madai halali yanalipwa kwa wakati .
1.6 Interpretation	In these Guidelines, unless the context requires otherwise; the following words shall mean: - **"Act"-** means the Universal Health Insurance Act, Cap 161. **"Authority"-** means Tanzania Insurance	**1.6 Tafsiri ya Maneno**	Katika Miongozo hii isipokua kama muktadha utaelekeza vinginevyo, maneno yafuatayo yatamaanisha: - **Sheria"** – maana yake ni Sheria ya Bima ya Afya kwa Wote, Sura ya 161. **"Mamlaka"** - maana yake ni Mamlaka ya Usimamizi

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	Regulatory Authority as established by the Insurance Act, Cap 394. **"Commissioner"** means Commissioner of Insurance and Chief Executive Officer of the Authority as established by the Insurance Act, Cap 394. **"Health insurance scheme"** means a registered entity that provides health insurance services in accordance with the provisions of the Act. **"Person"** means natural or legal person**.** **"Active Membership"** means a state whereby a person who has been registered by health insurance scheme has a valid Health Insurance Policy. **"Member"** means a person that holds a valid health insurance policy issued by a registered health insurance scheme. **"Beneficiary"** means a person who is entitled to receive medical benefits in accordance to the Act. **"Active beneficiery"** means a person who is		wa Bima Tanzania kama ilivyoanzishwa na Sheria ya Bima, Sura ya 394. **"Kamishna"** - maana yake ni Kamishna wa Bima na Mtendaji Mkuu wa Mamlaka kama alivyoanzishwa na Sheria ya Bima, Sura ya 394. **"Skimu ya bima ya afya"** maana yake ni kampuni au Taasisi iliyosajiliwa kutoa huduma za bima ya afya kwa mujibu wa masharti ya Sheria kama ilivyo elezwa kwenye Sheria. **"Mtu"** maana yake ni mtu au Taasisi. **Uanachama Hai"** maana yake ni hali ya mtu ambaye amesajiliwa na skimu ya bima ya afya na ana mkataba hai wa bima ya afya. **"Mwanachama"** maana yake ni mtu ambaye ana mkataba halali wa bima ya afya uliotolewa na skimu ya bima ya afya iliyosajiliwa. **"Mnufaika" maana** yake ni mtu anayestahili kupata mafao ya matibabu kwa mujibu Sheria. **"Mnufaika hai"** maana yake ni mtu anayestahili

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	entitled to receive health insurance benefits through a valid health insurance policy. **"Premium"** means the amount of money paid by the member or on behalf member to the health insurance scheme as consideration for health insurance coverage. **"Health Benefit package**" means health services provided to a beneficiary of health insurance scheme. **"Claims"** means a request from registered health service provider on payment or reimbursement for the medical services rendered to active beneficiaries of the health insurance scheme for a specific period as per service agreement signed between health insurance scheme and health service provider. **"Disputes"** means dissatisfaction between the insurance beneficiaries, the health insurance scheme, and or the health service provider, arising from various reasons including delayed claim payments, dissatisfaction with health services,		kupata mafao ya bima ya afya kupitia mkataba halali wa bima ya afya. **"Kiwango cha uchangiaji"** maana yake ni kiasi cha fedha kinacholipwa na mwanachama au kwa niaba ya mwanachama kwa skimu ya bima ya afya kama malipo kwa ajili ya huduma za bima ya afya. **"Mafao ya Afya"** maana yake ni huduma za afya zinazotolewa kwa mnufaika wa skimu ya bima ya afya. **"Madai"** maana yake ni ombi la malipo au urejeshaji wa gharama za matibabu kutoka kwa mtoa huduma za afya kwa ajili ya huduma za matibabu zilizotolewa kwa wanufaika hai wa bima katika kipindi maalum kwa mujibu wa mkataba wa makubaliano baina ya skimu ya bima ya afya na mtoa huduma za afya. **"Migogoro"** maana yake ni hali ya kutoridhika baina ya mnufaika wa bima, skimu ya bima ya afya na au mtoa huduma za afya kutokana na sababu mbalimbali ikiwemo ucheleweshwaji wa malipo ya madai, kutoridhishwa na huduma za matibabu, makato katika madai au masharti ya kimkataba

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	deductions from claims or unenforceable contractual terms. **"Claims Reconciliation"** refers to the process of reviewing, verifying and matching health service claims submitted by the health services provider to health insurance schemes to ensure payments align with the medical services billed. **"Health Service Provider (HSP)"** means a person registered by the Ministry responsible for health matters to provide health servises and registered by Authority. "**Ombudsman**" has the same meaning ascribed to it under the Insurance Act, Cap 394.		yasiyotekelezeka. **"Ulinganifu wa madai"** ni utaratibu wa kufanya mapitio, uhakiki na ulinganifu wa madai yaliyowasilishwa kati ya Skimu ya Bima ya afya na Mtoa huduma kwa huduma zilizotolewa. **"Mtoa Huduma za Afya (HSP)"** maana yake ni mtu aliyesajiliwa na Wizara inayohusika na masuala ya afya kutoa huduma za afya na kupewa usajili na Mamlaka. **"Msuluhishi wa migogoro ya bima"** ina maana sawa kama ilivyoelezwa katika Sheria ya Bima, Sura 394.

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2.1 Agreement between health insurance scheme and health service provider.	2.1.1. The Health Insurance Scheme shall enter into agreements with health service providers for a minimum period of one year and a maximum period of three years. 2.1.2. The agreements reffered to under clause 2.1.1, shall include at least the following; - a) The claims submission process to be adhered by health service provider; b) Mode of claims payment used by health insurance scheme either capitation, fee for service or other acceptable modes; c) Time limit for submission of claims by health service providers for services provided to beneficiary which shall be within thirty (30) days from the date of completion of the services; d) Essential documents to be attached during	**2.1 Makubaliano kati ya skimu ya bima ya afya na mtoa huduma za afya**	2.1.1 Skimu ya bima ya afya itaingia makubaliano na watoa huduma za afya kwa kipindi kisichopungua mwaka mmoja na kisichozidi miaka mitatu. 2.1.2 Mikataba inayorejewa katika kipengele cha 2.1.1 itajumuisha angalau yafuatayo: - a) Utaratibu wa uwasilishaji wa madai utakaozingatiwa na mtoa huduma za afya; b) Njia za ulipaji wa madai zitakazotumiwa na skimu ya bima ya afya ambazo zinaweza kuwa malipo kwa ujumla, malipo kwa mahudhurio au njia nyingine zinazokubalika; c) Ukomo wa muda wa kuwasilisha madai kwa mtoa huduma za afya kwa huduma zilizotolewa kwa mnufaika ambao utakuwa ndani ya siku thelathini (30) tangu tarehe ya kukamilika kwa huduma; d) Nyaraka muhimu zinazopaswa kuambatishwa wakati wa kuwasilisha

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	claims submission; e) Turn around time for claims processing and settlement as per the Act; f) Reasons for rejection of the whole or partial claim prior to payments; g) Conditions under which the agreement can be terminated such as breach of contract. h) Dispute resolution mechanisms; and i) Any other information as may be prescribed by the health insurance scheme		madai husika; e) Muda wa kushughulikia madai kwa mujibu wa Sheria; f) Sababu zinazoweza kupelekea kukataliwa kwa madai yote au sehemu ya madai kabla ya malipo; g) Masharti ambayo makubaliano yanaweza kusitishwa kama vile uvunjaji wa mkataba h) Utaratibu wa usuluhishi wa migogoro; na i) Taarifa nyingine yoyote kama inavyoweza kuainishwa na skimu ya bima ya afya.
2.2 Claim submission	2.2.1 The health service providers shall have systems that integrate with health insurance schemes for electronic claim submission. If the system is not compatible, the health scheme may provide alternative method of receiving health insurance claim with pripor written approval from Authorty.	**2.2 Uwasilishaji wa madai**	2.2.1 Watoa huduma za afya watatakiwa kuwa na mifumo inayoweza kuunganishwa na skimu za bima ya afya kwa ajili ya kuwasilisha madai kwa njia ya kielektroniki. Iwapo mfumo hautaendana, skimu ya bima ya afya inaweza kuweka njia mbadala ya kuwezesha uwasilishaji wa madai baada ya kupewa kibali na Mamlaka

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	2.2.2 For the purpose of claims submission, health service providers shall complete and submit an electronic claim form provided by the health insurance scheme. 2.2.3 Claim form at minimum shall contain the following; i. Patient's full name and signature; ii. Member Identification Number; iii. Authorization number; iv. Gender; v. Name of health insurance scheme; vi. Patient's treatments/Services rendered; vii. Diagnosis; viii. Costs of services; ix. Date of attendance; x. Name of service provider, Registration Number and signature; and xi. Patient certification; xii. Consent from members, for the scheme to access medical records of the member or beneficiary during claim		2.2.2 Kwa lengo la uwasilishaji wa madai, watoa huduma za afya watatakiwa kujaza na kuwasilisha fomu ya madai ya kielektroniki itakayotolewa na skimu ya bima ya afya. 2.2.3 Fomu ya madai itajumuisha angalau taarifa zifuatazo: i. Jina kamili la mgonjwa na sahihi; ii. Namba ya Uanachama; iii. Namba ya Idhini; iv. Jinsi; v. Jina la skimu ya bima ya afya; vi. Huduma zilizotolewa; vii. Uchunguzi wa kitabibu; viii. Gharama za matibabu; ix. Tarehe ya hudhurio; x. Jina la mtoa huduma wa afya, Namba ya Usajili na sahihi; na xi. Uthibitisho wa Mgonjwa; xii. Ridhaa kutoka kwa mwanachama, kuruhusu skimu kupata taarifa za matibabu za mwanachama au mnufaika wakati wa

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	processing. 2.2.4 Each claim form shall have a unique number and distinct components for each health service provider to facilitate tracking, and the health insurance scheme shall be required to generate specific serial numbers for each healthcare provider.		kushughulikia dai. 2.2.4 Kila fomu ya madai itakuwa na namba ya kipekee na vipengele tofauti kwa kila mtoa huduma za afya ili kurahisisha ufuatiliaji, na skimu ya bima ya afya itapaswa kutengeneza namba maalum za mfululizo kwa kila mtoa huduma za afya.
2.3 Claims acknowledgement	2.3.1 Health insurance scheme shall set up a mechanism that will notify the health service provider of acknowledgement and receipt for each respective claim for records and references. 2.3.2 The health insurance scheme shall notify the health service provider of receiving the claim within three (3) days after receiving the claims. 2.3.3 Health insurance scheme and health service provider shall implement a system to track and monitor the status of the claim.	**2.3 Utoaji wa taarifa ya kupokea madai**	2.3.1 Skimu ya bima ya afya itaweka utaratibu wa kutoa taarifa ya kukiri kupokelewa kwa madai kutoka kwa watoa huduma za afya kwa ajili ya rejea na kumbukumbu. 2.3.2 Skimu ya Bima ya Afya itamjulisha mtoa huduma za afya kuhusu kupokea madai ndani ya siku tatu (3) baada ya kupokea madai hayo. 2.3.3 Skimu ya bima ya afya na watoa huduma za afya wataweka mfumo kwa ajili ya kutoa taarifa na kufuatilia hali ya madai.

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	2.3.4 Health insurance scheme during its internal claims processing shall notify the health service providers of any doubtful or suspected fraudulent claims within thirty (30) days from the date of receipt of such claim.		2.3.4 Skimu ya bima ya afya, wakati wa uchakataji wa madai ndani ya mfumo wake wa ndani, itawajulisha watoa huduma za afya kuhusu madai yoyote yanayotiliwa shaka au yanayohisiwa kuwa ya udanganyifu ndani ya siku thelathini (30) tangu tarehe ya kupokea madai hayo.
2.4 Claim verification	Health insurance scheme shall establish a reliable and robust claim verification mechanism to ensure only genuine claims are reimbursed timely which shall: - i. Implement a robust system for claim verification which is capable of flagging any inconsistencies or fraud attempts; ii. Implement a check and balance system; iii. Provide ongoing training for staff responsible for verifying claims to ensure they understand the process and potential fraud risks; and iv. Conduct regular audits of claims to	**2.4 Uhakiki wa madai**	Skimu ya bima ya afya itaweka mfumo madhubuti wa utambuzi na uhakiki wa madai ili kuhakikisha ulipaji wa madai halali, ambao utawezesha: - i. Kutekeleza mfumo madhubuti wa uthibitishaji wa madai wenye uwezo wa kubaini dalili za udanganyifu; ii. Kutekeleza utaratibu wa udhibiti na uhakiki wa madai; iii. Kutoa mafunzo endelevu kwa wafanyakazi wanaohusika na uthibitishaji wa madai ili kuhakikisha wanaelewa mchakato na dalili za udanganyifu; na iv. Kufanya ukaguzi wa mara kwa mara wa

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	ensure accuracy and integrity.		madai ili kuhakikisha usahihi na uaminifu.
2.5 Claims Records Management	2.5.1 Health insurance scheme shall establish a proper mechanism for maintaining and keeping claims records in the form of electronic and physical. 2.5.2 Health insurance scheme shall retain claims records for a period of not less than 10 years. 2.5.3 Health service provider shall retain claims records for a period of not less than 10 years. 2.5.4 Health insurance scheme and health service provider shall ensure all informations and details contained in the claims form are treated with care and a high level of confidentiality to protect the interest of beneficiaries as per the Personal Data Protection Act.	**2.5 Utunzaji wa kumbukumbu za madai**	2.5.1 Skimu ya bima ya afya itaweka mfumo mahususi kwa ajili ya utunzaji wa kumbukumbu za madai kutoka kwa watoa huduma za afya kwa njia ya kieletroniki na nakala ngumu; 2.5.2 Skimu za bima ya afya itahifadhi rekodi za madai kwa kipindi kisichopungua miaka 10. 2.5.3 Mtoa huduma za afya atahifadhi kumbukumbu za madai kwa kipindi kisichopungua miaka 10. 2.5.4 Skimu ya bima ya afya na mtoa huduma za afya watahakikisha kuwa taarifa zote zilizopo katika fomu za madai zinatunzwa kwa usiri mkubwa ili kukinga haki ya mnufaika wa huduma za bima kama inavyotakiwa na Sheria ya Ulinzi wa Taarifa Binafsi.

SECTION THREE: REIMBURSEMENT OF CLAIMS		SEHEMU YA TATU : MALIPO YA MADAI	
3.1 Reimbursement of claims	3.1.1 The health insurance scheme shall reimburse valid claims submitted by health service providers within a period not exceeding 60 days from the date of receipt of the claims. 3.1.2 All claims received by the health insurance scheme, shall be reimbursed on a First -In-First Out (FIFO) principle. Any deviations from such principle must be accompanied by an explanation from the health insurance scheme.	**3.1 Ulipaji wa malipo**	3.1.1 Skimu ya bima ya afya italipa madai halali ndani ya kipindi kisichozidi siku 60 tangu tarehe ya kupokea madai hayo. 3.1.2 Madai yatakayopokelewa na skimu yatalipwa kwa kuzingatia utaratibu wa madai yaliyopokelewa kwanza na kufuatiwa na yaliyopokelewa kwa kuchelewa. Mabadiliko yoyote kutoka kwa utaratibu huo yanapaswa kuambatana na maelezo kutoka kwa skimu ya bima ya afya.
3.2 Notification for reimbursed claims	3.2.1 Health insurance scheme shall establish a proper mechanism that will facilitate provision of notice to heath service providers upon completion of reimbursement. The optimal mechanism for notification should ensure efficiency, transparency, and accountability. 3.2.2 The mechanism for notifying reimbursed claims, which the health insurance scheme shall establish, must,	**3.2 Taarifa ya malipo ya madai**	3.2.1 Kila skimu ya bima ya afya itaweka utaratibu mahususi wa utoaji wa notisi ya taarifa ya malipo ya madai. Utaratibu bora wa kutoa taarifa unapaswa kuhakikisha ufanisi, uwazi, na uwajibikaji. 3.2.2 Utaratibu wa kutoa notisi kuhusu malipo ya madai, ambao skimu ya bima ya afya inapaswa kuanzisha, kwa kiwango cha chini, utajumuisha yafuatayo;

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	at a minimum, include the following; - i. Claim reference number; ii. Date of claim submission; iii. Payment date; iv. Amount paid; v. Any deductions made; and vi. If rejected or partially reimbursed, reasons for the decision must be provided.		i. Nambari rejea ya madai; ii. Tarehe ya kuwasilisha madai; iii. Tarehe ya malipo; iv. Kiasi kilicholipwa; v. Makato yoyote yaliyofanyika; na vi. Ikiwa madai yamekataliwa au yameidhinishwa kwa sehemu, sababu za uamuzi zinapaswa kutolewa.

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3.3 Claims Reconciliation	3.3.1 Health insurance schemes shall establish a documented procedure that will facilitate reconciliation of claims when need arises. 3.3.2 The health service provider shall prepare and submit justification for claims reconciliation whenever such reconciliation is required and must identify and document the areas of discrepancy. Such submission shall be made within 15 working days from the date the specific claims were reimbursed. 3.3.3 Health insurance scheme upon satisfaction, shall ensure reimbursement for reconciled items is done within 15 working days from the date when reconciliation was completed or inform the health service provider the reasons for rejection. 3.3.4 For non-disputable claims, payment should be made immediately. The disputable claims can undergo the reconciliation	**3.3 Ulinganifu wa madai**	3.3.1 Skimu ya bima ya afya itaweka utaratibu kwa ajili ya kufanya ulinganifu wa madai endapo italazimika kufanya hivyo. 3.3.2 Mtoa huduma za afya ataandaa na kuwasilisha maelezo ya uhalali wa upatanisho wa madai kila inapohitajika, na kitabainisha na kuandika maeneo yenye tofauti. Uwasilishaji huo utafanyika ndani ya siku 15 za kazi tangu tarehe ya malipo ya madai husika. 3.3.3 Skimu ya bima ya afya baada ya kujiridhisha na ulinganifu inatakiwa kulipa madai husika ndani ya siku 15 za kazi tangu tarehe ya kukamilika kwa zoezi la ulinganifu au kutoa taarifa ya kutolipa madai husika kutokana na matokeo ya ulinganifu. 3.3.4 Kwa madai yasio na mgogoro, malipo yafanyike mara moja. Madai yaliyo na mgogoro yaende katika mchakato wa ulinganifu lakini hayapaswi kuchelewesha

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	process, but it should not delay the payment of the undisputed portion. 3.3.5 The reconciliation team shall include representatives from both, the health insurance scheme and the health service providers. 3.3.6 The Health Insurance Scheme shall provide the health service provider with a form of complete reconciliation process. 3.3.7 Where parties fail to reconcile amicably, the aggrieved party may submit the matter to the Authority or Insurance Ombudsman.		malipo ya madai yasiyo na mgogoro. 3.3.5 Timu ya ulinganifu wa madai itajumuisha wawakilishi kutoka Skimu ya bima ya afya na watoa huduma za afya. 3.3.6 Skimu ya Bima ya Afya itamjazisha mtoa huduma za afya fomu ya kukamilisha mchakato wa ulinganifu. 3.3.7 Iwapo pande husika zitashindwa kufanya ulinganisho kwa maelewano, upande usioridhika unaweza kuwasilisha suala hilo kwa Mamlaka au Msuluhishi wa Migogoro ya Bima .

SECTION FOUR: MONITORING MECHANISM FOR SERVICE DELIVERY		SEHEMU YA NNE: UTARATIBU WA UFUATILIAJI HUDUMA	
4.1 Monitoring of Service	4.1.1 Health insurance scheme shall establish monitoring mechanism for delivery of health services to ensure interest of policyholders are protected during access to medical services and submitted claims for reimbursement are consistency. 4.1.2 In implementing 4.1.1 above each health insurance scheme shall establish monitoring and evaluation mechanish which shall facilitate the following: - a) Undertake routine onsite verifications on quality-of-service delivery at health service providers and report on Annual basis to the Authority; b) Undertake routine sensitization and awareness programmes to health service providers and beneficiaries; and submit Annually to the Authority; c) Have a robust ICT system for verification of beneficiaries and medical practictioners at	**4.1 Ufuatiliaji wa utoaji huduma**	4.1.1 Skimu ya bima ya afya itaweka mfumo wa ufuatiliaji wa utoaji wa huduma za matibabu ili kulinda maslahi ya wanufaika wa bima na kuhakikisha kuwa madai yanayowasilishwa kwa ajili ya malipo ni halali kulingana na huduma zilizotolewa; 4.1.2 Katika kutekeleza kipengele cha 4.1.1, skimu ya bima ya afya itaandaa mfumo wa ufuatiliaji na tathmini ambao utawezesha yafuatayo: - a) kufanya kaguzi za mara kwa mara kwa watoa huduma za afya ili kuhakiki utoaji wa huduma bora na kuripoti kwa Mamlaka kila mwaka; b) Kutoa elimu kwa watoa huduma na wanufaika wa skimu za bima ya afya na kuripoti kwa Mamlaka kila mwaka; c) Kuwa na mfumo wa kieletroniki wa uhakiki wa wanufaika na wataalamu wa tiba katika vituo vya kutolea huduma za afya.

SECTION FOUR: MONITORING MECHANISM FOR SERVICE DELIVERY		SEHEMU YA NNE: UTARATIBU WA UFUATILIAJI HUDUMA	
	health service providers. 4.1.3 The health insurance scheme shall notify the Authority monthly of any complaints from beneficiaries or health service provider that remain unresolved beyond 30 days. 4.1.4 The health service provider shall establish internal monitoring system for the services being provided to beneficiaries, such that services are provided as per Standard Treatment Guidelines and other guidelines issued by the Ministry responsible for Health matters.		4.1.3 Skimu ya bima ya afya itatoa taarifa kila mwezi mwaka kwa Mamlaka kuhusu malalamiko kutoka kwa wanufaika wa bima ya afya au watoa huduma za afya ambayo hayajapata suluhu ndani ya siku 30. 4.1.4 Mtoa huduma za afya ataanzisha mfumo wa ndani wa ufuatiliaji wa huduma zinazotolewa kwa wanufaika wa bima ya afya, ili kuhakikisha kuwa huduma zinatolewa kwa kuzingatia Miongozo ya Matibabu ya Viwango vya Kitaifa pamoja na miongozo mingine iliyowekwa na Wizara yenye dhamana na masuala ya Afya.
4.2 Fraud Practises	4.2.1 Health insurance scheme shall establish a robust fraud prevention measure to ensure claims submitted are genuine for reimbursement. 4.2.2 Undertake routine preventive and investigative measures on fraudulent practices commited by beneficiary or health service providers; 4.2.3 The health insurance scheme shall submit a monthly fraudulent report to the Authority on	**4.2 Vitendo vya udanganyifu**	4.2.1 Skimu ya bima ya afya itaweka mfumo wa kudhibiti udanganyifu ili kuhakikisha kuwa madai yanayowasilishwa ni halali. 4.2.2 kudhibiti na kufanya uchunguzi wa mara kwa wa vitendo vya udanganyifu vilivyofanywa na wanufaika wa bima au watoa huduma za afya na kuchukua hatua stahiki; 4.2.3 Skimu ya bima ya afya itatoa taarifa kila

SECTION FOUR: MONITORING MECHANISM FOR SERVICE DELIVERY		SEHEMU YA NNE: UTARATIBU WA UFUATILIAJI HUDUMA	
	fraud actitivties condected by beneficiary or health service provider for further regulatory action.		mwezi kwa Mamlaka juu ya vitendo vya udanganyifu vilivyofanywa na wanufaika wa bima au watoa za afya kwa hatua zaidi za udhibiti.

SECTION FIVE: ROLES AND RESPONSIBILITIES		SEHEMU YA TANO: MAJUKUMU NA WAJIBU	
5.1 Health Insurance Scheme	Every Health Insurance Scheme shall: - a) Establish suistanable awareness programme for health service providers on procedure and salient issues to be observed during claims processing; b) Facilitate availability of ICT platform to enable claims submission from health service providers; c) Undertake offsite and onsite health services provider inspections to ensure submitted claims are genuine and from rightful beneficiaries; d) Ensure valid claims form health service providers are reimbursed as within a period not exceeding 60 days from the date of receipt of the claim; and	**5.1 Skimu ya Bima ya Afya**	Kila skimu ya bima ya afya: - a) Itaweka mpango wa utoaji elimu endelevu kwa watoa huduma za afya kuhusu utaratibu na masuala muhimu ya kuzingatiwa wakati wa uwasilishaji wa madai; b) Itawezesha mazingira ya uwekaji wa mifumo ya kieletroniki ili kuwezesha watoa huduma za afya kuwasilisha madai; c) Itafanya kaguzi kwa kufika katika vituo au kupitia mfumo mwingine wa kaguzi ili kuhakikisha kuwa madai yote yanayowasilishwa ni halali na wahusika waliopewa huduma za matibabu ni wanufaika stahiki;

SECTION FIVE: ROLES AND RESPONSIBILITIES		SEHEMU YA TANO: MAJUKUMU NA WAJIBU	
	e) Submit to the Authority claims report on quarterly basis.		d) Itahakikisha kuwa madai halali kutoka kwa watoa huduma za afya yanalipwa ndani ya siku 60 tangu tarehe ya kupokea madai hayo; na e) Itawasilisha taarifa ya malipo ya madai kwa Mamlaka kila robo mwaka.
5.2 Health services providers	Every Health Service provider shall: - a) Adhere to claims submission process set by the health insurance schemes including time limit for submission of claims; b) Review reasons for deductions made on claims by health insurance schemes within the prescribed time period and seek for reconciliation if need arise; c) Implement and adhere to membership identification mechanism set by heath insurance scheme prior provision of medical services to beneficiaries; d) Observe and adhere to requirements set by health insurance scheme for filling of claims forms prior submission; and	**5.2 Mtoa Huduma za afya**	Mtoa huduma za afya: - a) Atazingatia utaratibu wa uwasilishaji wa madai uliowekwa na skimu ikiwemo ukomo wa muda wa kuwasilisha madai; b) Atafanya mapitio ya sababu za makato yaliyofanyika kwenye madai ndani ya kipindi kilichoainishwa na kuomba ulinganifu kama italazimu; c) Ataweka na kuzingatia mfumo wa utambuzi wa wanufaika wa bima ya afya uliowekwa na skimu kabla ya kuruhusu wanufaika kupata huduma za matibabu; d) Atazingatia taratibu za ujazaji wa fomu za madai uliowekwa na skimu ya bima ya afya kabla ya kuwasilisha madai; na

SECTION FIVE: ROLES AND RESPONSIBILITIES		SEHEMU YA TANO: MAJUKUMU NA WAJIBU	
	e) Adhere to complaint handling procedures as specified by the Authority in relation to insurance claims matters.		e) Atazingatia taratibu za ushughulikiaji wa malalamiko zilizowekwa na Mamlaka kuhusu madai ya bima.
5.3 Beneficiaries of the health insurance scheme	Every beneficiary of the Scheme shall; 5.3.1 Present membership identification at health facility prior to accessing medical service; 5.3.2 Acknowledge medical services rendered to him by health service providers; 5.3.3 Report any mistreatment by the scheme or health service provider in accordance to complaints handling mechanism as provided by the Authority; and 5.3.4 Health service providers shall cooperate with the health insurance scheme whenever required, particularly during fraud investigations or any other inquiries related to claims.	**5.3 Wanufaika wa skimu ya bima ya afya**	Kila mnufaika wa skimu; 5.3.1 Atawasilisha namba ya uanachama katika kituo cha afya kabla ya kupata huduma za matibabu; 5.3.2 Atakiri kupokea huduma za matibabu zilizotolewa kwake na mtoa huduma za afya; 5.3.3 Atatoa taarifa yoyote ya kutotendewa sawa na skimu au mtoa huduma za afya kwa kufuata utaratibu wa kushughulikia malalamiko kama ulivyowekwa na Mamlaka; na 5.3.4 Mtoa huduma atashirikiana na skimu ya bima ya afya wakati wowote atakapohitajika kufanya hivyo, hususani wakati wa uchunguzi wa vitendo vya udanganyifu au suala lolote linalohusu madai.

SECTION SIX: PROHIBITED PRACTICES		SEHEMU YA SITA: MAKATAZO	
6.1 Prohibited practices for Health Insurance Scheme	6.1.1 The health insurance schemes are prohibited from: (a) Entering into agreements with health service providers both inside and outside Republic of Tanzania who are not registered by the Authority. (b) Pay any health insurance claims to health service providers located outside the United Republic of Tanzania without obtaining approval from the Authority. (c) Disclosing patient or member information without consent, except as required by law.	**6.1 Makatazo kwa Skimu za bima ya afya**	6.1.1 Skimu ya bima ya afya haitaruhusiwa: (a) Kuingia makubaliano na watoa huduma za afya wa ndani au nje ya Jamhuri ya Muungano wa Tanzania wasiosajiliwa na Mamlaka. (b) Kulipa madai yoyote ya bima ya afya kwa watoa huduma za afya walioko nje ya Jamhuri ya Muungano wa Tanzania bila kupata kibali kutoka kwa Mamlaka. (c) kutoa taarifa za mgonjwa au mwanachama bila idhini, isipokuwa pale ambapo sheria inahitaji kufanya hivyo.
6.2 Prohibited practices for Health Service providers	6.2.1 Health service providers are prohibited from offering health insurance services unless they fully comply with the terms and conditions outlined in the service agreement with the health insurance scheme. 6.2.2 Health service providers shall not demand out-of-pocket payments from beneficiaries for services included in the benefit package,	**6.2 Makatazo kwa watoa huduma za afya**	6.2.1 Watoa huduma za afya hawataruhusiwa kutoa huduma za bima ya afya isipokuwa kwa kuzingatia masharti na vigezo vilivyowekwa kwenye mkataba wa huduma kati ya skimu ya bima ya afya na mtoa huduma za afya; 6.2.2 Mtoa huduma za afya hataruhusiwa kudai malipo kwa fedha taslimu kutoka kwa mnufaika kwa ajili ya huduma zilizojumuishwa kwenye

SECTION SIX: PROHIBITED PRACTICES		SEHEMU YA SITA: MAKATAZO	
	except where explicitly permitted by the service agreement. 6.2.3 Health service providers shall not suspend offering services to beneficiaries regardless of delays in claim settlements by the scheme. Suspension of services may only occur in accordance with the procedures stipulated in the contractual agreement. 6.2.4 Health service providers shall avoid submission of ficticious claims for reimbursement.		kitita cha mafao, isipokuwa kama mkataba wa huduma unaruhusu hivyo. 6.2.3 Mtoa huduma za afya hataruhusiwa kusitisha utoaji wa huduma kwa wanufaika kutokana na ucheleweshaji wa malipo ya madai kutoka kwa skimu. Usitishaji wa huduma unaweza kufanyika kwa kufuata taratibu zilizowekwa katika mkataba wa makubaliano. 6.2.4 Watoa huduma za afya hawataruhusiwa kuwasilisha madai ya uongo au ya kughushi kwa ajili ya kurejeshewa malipo.
6.3 Prohibited practices for Beneficiaries	6.3.1 Beneficiaries must avoid engaging in, participating in, or colluding with health service providers in any fraudulent practices related to claims. 6.3.2 Beneficiaries shall not be allowed to use someone else's identity to access health services. 6.3.3 Beneficiaries shall not provide false information or documents when seeking medical services	**6.3 Makatazo ya wanufaika**	6.3.1 Wanufaika hawataruhusiwa kujihusisha, kushiriki au kushirikiana na watoa huduma za afya katika vitendo vyovyote vya udanganyifu vinavyohusiana na madai. 6.3.2 Wanufaika hawataruhusiwa kutumia utambulisho wa mtu mwingine ili kupata huduma za afya. 6.3.3 Wanufaika hawataruhusiwa kutoa taarifa au nyaraka za uongo wanapotaka kupata huduma

SECTION SIX: PROHIBITED PRACTICES		SEHEMU YA SITA: MAKATAZO	
	or filing insurance claims.		za matibabu au wanapowasilisha madai ya bima.

SECTION SEVEN: GENERAL PROVISIONS		SEHEMU YA SABA:	
7.1. Sanctions	Any person who contravenes the provisions of these Guidelines commits an offense and such act shall be subject to penalties as prescribed by the Act.	**7.1 Adhabu**	Mtu yeyote ambaye atakiuka masharti ya Miongozo hii atakuwa ametenda kosa na ataadhibiwa kama ilivyoelezwa katika Sheria.
7.2. Effective date	7.2.1 These Guidelines shall come into force on the 1st of September 2025.	**7.2 Tarehe ya kuanza kutumika**	7.2.1 Miongozo hii itaanza kutumika rasmi tarehe 1 Septemba, 2025.
SECTION EIGHT: REVIEW AND APPROVAL		**SEHEMU YA NANE: MAPITIO NA IDHINI**	
8.1 Review of Guidelines	8.1.1 These Guidelines shall be reviewed once every three years; and 8.1.2 Subject to clause 8.1.1, the Authority may issue an addendum that shall form part of these Guidelines.	**8.1 Mapitio ya Miongozo**	8.1.1 Miongozo hii itafanyiwa mapitio mara moja kila baada ya miaka mitatu; na 8.1.2 Kwa kuzingatia kipengele cha 8.1.1, Mamlaka inaweza kutoa Nyongeza ya Miongozo ambayo itakuwa sehemu ya Miongozo hii.
Approved by:	 Digitally Signed By Dr. Baghayo A. Saqware Fri Aug 29 15:18:35 EAT 2025 Dr. Baghayo A. Saqware COMMISSIONER OF INSURANCE	**Imepitishwa na:**	 Digitally Signed By Dr. Baghayo A. Saqware Fri Aug 29 15:21:17 EAT 2025 Dr. Baghayo A. Saqware KAMISHNA WA BIMA

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