

CMS-1500 HEALTH INSURANCE CLAIM FORM EXAMPLE

PATIENT INFORMATION

| | |
|-----------------|-----------|
| Name: | Mazen |
| DOB: | 22/2/2000 |
| Gender: | Male |
| Address: | N/A |
| Phone: | N/A |
| Age: | 22 |

INSURANCE INFORMATION

| | |
|------------------|--------|
| Provider: | Metlif |
| Policy #: | AS12 |
| Group #: | N/A |

CLINICAL INFORMATION

| | |
|--------------------------|----------|
| Place of service: | Hospital |
|--------------------------|----------|

DIAGNOSIS CODES (ICD-10)

| Code | Description |
|--------|--|
| R040 | Epistaxis |
| M24452 | Recurrent dislocation, left hip |
| N950 | Postmenopausal bleeding |
| M24351 | Pathological dislocation of right hip, NEC |

PROCEDURE CODES (CPT-4)

| Code | Description |
|-------|---------------------------|
| 27095 | Injection for hip x-ray |
| 82800 | Blood pH |
| 70470 | Ct head/brain w/o & w/dye |

This is a computer-generated form created by AI Medical Coding Assistant.

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