

# AAHAM Certified Revenue Cycle Specialist - Professional (CRCS-P) Practice Test (Sample)

## Study Guide



**Everything you need from our exam experts!**

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# Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

**Remember:** successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

# How to Use This Guide

**This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:**

## **1. Start with a Diagnostic Review**

**Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.**

## **2. Study in Short, Focused Sessions**

**Break your study time into manageable blocks (e.g. 30 - 45 minutes). Review a handful of questions, reflect on the explanations.**

## **3. Learn from the Explanations**

**After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.**

## **4. Track Your Progress**

**Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.**

## **5. Simulate the Real Exam**

**Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.**

## **6. Repeat and Review**

**Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.**

**There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!**

## Questions

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- 1. What does HRSA stand for?**
  - A. Health Resources and Services Administration**
  - B. Health Regulation and Safety Authority**
  - C. Health Research and Services Alliance**
  - D. Health Resources and Safety Agency**
  
- 2. What does MCO stand for within the healthcare context?**
  - A. Managed Care Organizations**
  - B. Medical Care Operatives**
  - C. Medicare Care Options**
  - D. Monitored Care Organization**
  
- 3. What is a condition for home health care to be reimbursed by Medicare?**
  - A. The patient must require long-term care**
  - B. A physician must certify that the patient is home bound**
  - C. The patient must be admitted to a hospital**
  - D. The care must be provided in a nursing facility**
  
- 4. What is an example of a clerical error that could cause a "false" skip in billing?**
  - A. Incorrect insurance policy number**
  - B. Misspelled patient names**
  - C. Incomplete street address information**
  - D. Missing date of service**
  
- 5. When is the Initial Enrollment Questionnaire (IEQ) mailed to patients?**
  - A. One month before they turn 65**
  - B. Three months after they enroll in Medicare**
  - C. Three months before they become entitled to Medicare**
  - D. Upon diagnosis of a chronic illness**

- 6. What does QA stand for in the quality management context?**
- A. Quality Assurance**
  - B. Qualified Assessment**
  - C. Quality Analysis**
  - D. Quantitative Assessment**
- 7. What is an imprest system typically used for?**
- A. Managing supplier contracts**
  - B. Handling petty cash transactions**
  - C. Billing insurance companies**
  - D. Tracking payroll expenses**
- 8. In what scenario would a Non-Availability Statement (NAS) be utilized?**
- A. For recording patient complaints**
  - B. When a treatment is unavailable in a specific area**
  - C. For verifying insurance coverages**
  - D. When determining coding errors**
- 9. What is another name for the Emergency Medical Treatment and Active Labor Act?**
- A. Federal Anti-Dumping Statute**
  - B. Healthcare Fraud Prevention Act**
  - C. Patient Protection Act**
  - D. Healthcare Coverage Act**
- 10. What is another term for Average Days of Revenue in Accounts Receivable?**
- A. Revenue Cycle Management Days**
  - B. Accounts Receivable (AR) Days Outstanding**
  - C. Accounts Payable Days**
  - D. Total Turnover Days**

## Answers

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1. A
2. A
3. B
4. C
5. C
6. A
7. B
8. B
9. A
10. B

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## **Explanations**

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## 1. What does HRSA stand for?

**A. Health Resources and Services Administration**

**B. Health Regulation and Safety Authority**

**C. Health Research and Services Alliance**

**D. Health Resources and Safety Agency**

The correct answer is Health Resources and Services Administration. This is a U.S. government agency that provides information and resources related to health care services, focusing on improving access to health care for people who are uninsured, isolated, or medically vulnerable. HRSA administers programs that improve health care delivery, ensures that health care is accessible to everyone, and addresses workforce issues in health care. In the context of revenue cycle management and health care services, understanding HRSA is important because the agency plays a key role in funding health care programs, which can impact the financial operations of health care providers. Knowledge of HRSA is essential for professionals working in revenue cycles as they may need to navigate funding, grants, and regulations that come from this agency, particularly when dealing with programs that serve at-risk populations.

## 2. What does MCO stand for within the healthcare context?

**A. Managed Care Organizations**

**B. Medical Care Operatives**

**C. Medicare Care Options**

**D. Monitored Care Organization**

Managed Care Organizations (MCOs) play a crucial role in the healthcare system by coordinating the delivery of healthcare services and managing the costs associated with those services. They are responsible for providing a network of healthcare providers to deliver care to enrolled members while ensuring that patients receive appropriate and necessary services. The concept of managed care focuses on improving the quality of care, enhancing patient outcomes, and reducing overall healthcare costs through integrated service delivery. MCOs typically work with healthcare providers to establish contracts and create care plans that streamline patient treatment while controlling costs. This model often includes features such as pre-authorizations for specific services, managed care plans that incentivize preventive care, and payment structures that encourage efficiency. By managing both the quality and the costs of healthcare services, MCOs contribute significantly to the efficiency of the healthcare landscape. The other options do not represent established terms or organizations commonly recognized in the healthcare arena. This reinforces the validity of Managed Care Organizations as the correct answer, as it is the widely accepted and utilized terminology within the industry.

**3. What is a condition for home health care to be reimbursed by Medicare?**

- A. The patient must require long-term care**
- C. A physician must certify that the patient is home bound**
- B. The patient must be admitted to a hospital**
- D. The care must be provided in a nursing facility**

For home health care to be reimbursed by Medicare, it is essential that a physician certifies that the patient is home bound. This condition is in place because Medicare seeks to ensure that home health care is necessary for patients who cannot easily leave their homes to receive medical treatment. Being "home bound" generally means that the patient has a condition that restricts their ability to leave home without significant difficulty or assistance. This certification plays a crucial role in validating the need for home health services, thereby allowing Medicare to approve reimbursement for the care provided in a home setting. The requirement is focused on ensuring that patients who need these services truly benefit from receiving care at home due to their medical conditions and mobility limitations. In contrast, the other options do not align with Medicare's criteria for home health reimbursement. Long-term care is not a requirement under the home health benefit, nor is hospitalization prior to receiving home health services mandated. Additionally, care provided within a nursing facility is outside the scope of home health care focused on delivering services in the home environment.

**4. What is an example of a clerical error that could cause a "false" skip in billing?**

- A. Incorrect insurance policy number**
- B. Misspelled patient names**
- C. Incomplete street address information**
- D. Missing date of service**

An incomplete street address can lead to a "false" skip in billing because billing systems often rely on accurate and complete information to process and send claims. When a street address is incomplete, it can hinder the ability of the billing department to verify patient information or reach the correct payer for reimbursement. This could result in claims being flagged incorrectly as unbillable or not sent out at all, thereby creating a billing "skip." It's essential to ensure that all data fields, particularly those involving patient identification and contact information, are filled out completely to allow for smooth processing. While incorrect insurance policy numbers, misspelled patient names, and missing dates of service are also important factors that can affect the billing process, an incomplete street address specifically may stop the entire billing process if the system cannot locate the patient or send the claim to the right address.

**5. When is the Initial Enrollment Questionnaire (IEQ) mailed to patients?**

- A. One month before they turn 65**
- B. Three months after they enroll in Medicare**
- C. Three months before they become entitled to Medicare**
- D. Upon diagnosis of a chronic illness**

The Initial Enrollment Questionnaire (IEQ) is a tool used to gather information from patients who are preparing to enroll in Medicare. The correct timing for mailing the IEQ is three months before individuals become entitled to Medicare, which typically occurs when they turn 65, or if they are eligible due to other circumstances, such as a disability. Mailing the IEQ at this time allows patients to receive important information about their Medicare options and helps ensure they are prepared for enrollment. This proactive approach facilitates a smoother transition into the Medicare system, providing beneficiaries with ample time to review their choices and understand their benefits. Receiving the IEQ three months in advance also aligns with the broader enrollment timeline for Medicare, enabling individuals to make informed decisions about their healthcare as they approach this significant milestone.

**6. What does QA stand for in the quality management context?**

- A. Quality Assurance**
- B. Qualified Assessment**
- C. Quality Analysis**
- D. Quantitative Assessment**

In the context of quality management, QA stands for Quality Assurance. Quality Assurance refers to the systematic process implemented within organizations to ensure that products and services meet specified quality standards consistently. It involves the entire process of production or service delivery, focusing on preventing defects and ensuring that the final output meets the desired criteria. Quality Assurance encompasses various activities, including the establishment of standards, auditing processes, training of personnel, and continuous improvement initiatives. This approach is crucial in fostering a culture of quality and accountability within organizations, leading to customer satisfaction and compliance with regulations. The other options emphasize different aspects of quality or assessment without incorporating the comprehensive scope that Quality Assurance entails, making them less suitable for defining QA in this context.

## 7. What is an imprest system typically used for?

- A. Managing supplier contracts
- B. Handling petty cash transactions**
- C. Billing insurance companies
- D. Tracking payroll expenses

The imprest system is commonly used for handling petty cash transactions because it provides a controlled and efficient way to manage small amounts of cash for incidental expenses. In this system, a fixed amount of cash is set aside to cover minor expenses, and as expenditures occur, they are documented and logged. When the cash is running low, the fund is replenished to its original fixed amount by submitting a request for reimbursement based on the documented expenses. This ensures that there is a clear record of spending and helps maintain accountability for cash disbursed for everyday operational needs. Utilizing an imprest system mitigates the risk of cash mishandling and ensures reimbursements are based solely on actual expenses incurred, making it a reliable method for managing petty cash. The other options mentioned involve different aspects of finance and accounting, such as supplier contracts, insurance billing, or payroll tracking, which do not align with the primary purpose of an imprest system.

## 8. In what scenario would a Non-Availability Statement (NAS) be utilized?

- A. For recording patient complaints
- B. When a treatment is unavailable in a specific area**
- C. For verifying insurance coverages
- D. When determining coding errors

A Non-Availability Statement (NAS) is specifically utilized in healthcare settings when a treatment or service is not available in a specific geographical area. This document is a crucial part of the medical billing and claims process, particularly within the context of certain insurance programs, like Medicaid or TRICARE. When a provider cannot deliver a required service due to regional limitations, a NAS may be necessary to confirm that the treatment option was sought but ultimately unavailable. This enables patients to seek coverage for services rendered elsewhere, ensuring that providers are compensated appropriately for the care delivered outside the usual network or area. The other scenarios listed do not align with the specific purpose of a Non-Availability Statement. For instance, recording patient complaints is more aligned with patient advocacy and quality assurance rather than the financial or claims processing aspects where a NAS is applicable. Verifying insurance coverages pertains to understanding a patient's insurance benefits and eligibility but does not involve the unavailability of services. Determining coding errors relates to the accuracy of billing practices and does not connect with the issue of availability of medical services in a location.

**9. What is another name for the Emergency Medical Treatment and Active Labor Act?**

- A. Federal Anti-Dumping Statute**
- B. Healthcare Fraud Prevention Act**
- C. Patient Protection Act**
- D. Healthcare Coverage Act**

The Emergency Medical Treatment and Active Labor Act (EMTALA) is commonly referred to as the Federal Anti-Dumping Statute. This legislation mandates that hospitals provide emergency medical treatment to individuals irrespective of their insurance status or ability to pay. It was enacted to prevent hospitals from refusing treatment or "dumping" patients who are unable to pay, particularly those with emergency conditions. The name reflects the law's intent to ensure that all patients receive appropriate emergency care without financial discrimination, outlining the obligations of healthcare providers in emergency scenarios. The other options pertain to different aspects of healthcare regulation and do not accurately represent EMTALA. The Healthcare Fraud Prevention Act primarily focuses on preventing fraud and abuse in healthcare programs. The Patient Protection Act is more closely associated with the protection of patients' rights and access to healthcare. The Healthcare Coverage Act refers to legislation concerning insurance coverage and does not address emergency care specifically. Thus, A accurately identifies the primary alternative name for EMTALA.

**10. What is another term for Average Days of Revenue in Accounts Receivable?**

- A. Revenue Cycle Management Days**
- B. Accounts Receivable (AR) Days Outstanding**
- C. Accounts Payable Days**
- D. Total Turnover Days**

The term "Average Days of Revenue in Accounts Receivable" is commonly referred to as Accounts Receivable (AR) Days Outstanding. This metric represents the average number of days it takes for a company to collect payments from its customers after a sale has been made. It provides insight into the efficiency of a company's billing and collection processes, as well as its overall cash flow management. By tracking AR Days Outstanding, organizations can assess their performance in collecting debts and make necessary adjustments to their credit policies or collection strategies. A higher number of days could indicate issues such as slow collection processes or customer payment delays, whereas a lower number suggests effective collections and potentially better cash flow. In contrast, other terms provided in the options do not accurately represent the same concept. For instance, Revenue Cycle Management Days may refer to the broader management of the revenue cycle and not specifically to the collection of accounts receivable. Accounts Payable Days pertains to how quickly a business pays its suppliers, which is not related to receivables. Total Turnover Days is a broader financial metric that often looks at overall asset turnover, making it different from the specific focus on accounts receivable.

## Next Steps

**Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.**

**As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.**

**If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at [hello@examzify.com](mailto:hello@examzify.com).**

**Or visit your dedicated course page for more study tools and resources:**

**<https://aahamcrcsp.examzify.com>**

**We wish you the very best on your exam journey. You've got this!**

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