

AHIP FRAUD, WASTE, AND ABUSE (FWA) PRACTICE EXAM (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

**VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE**

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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 is the advantage of enrolling in a Medicare Advantage plan for Ms. Thomas?**
 - A. Decreased premiums
 - B. Increased coverage options
 - C. Guaranteed acceptance
 - D. Lower deductibles
- 2. What should you do upon discovering unreported discrepancies about enrollees in a monthly report?**
 - A. Ignore it as instructed by your supervisor
 - B. Report it through your compliance department's anonymous tip line
 - C. Discuss it openly with other coworkers
 - D. Document it and forget about it
- 3. What types of insurance products can be presented during a Medicare Advantage and Part D marketing appointment?**
 - A. Only health care related lines of business with permission
 - B. All types of insurance products available
 - C. Only Medicare Advantage plans
 - D. Only Medigap policies
- 4. Who among Miles' clients qualifies for the opt-in simplified enrollment mechanism?**
 - A. Charles, who just turned 65.
 - B. Adam and Betty, who have continuous coverage.
 - C. Diedre, who has coverage through another company.
 - D. All clients qualify for the mechanism.
- 5. Which practice can significantly contribute to identifying and preventing FWA?**
 - A. Conducting routine audits
 - B. Allowing unrestricted access to patient data
 - C. Working independently without guidance
 - D. Deferring decisions to third parties

- 6. What happens to Juan Perez's employer-sponsored healthcare coverage when he enrolls in Medicare?**
- A. Medicare becomes the secondary payor for his claims.
 - B. He must choose between Medicare and employer coverage.
 - C. Medicare becomes the primary payor for his healthcare claims.
 - D. His employer must continue to provide coverage comparable to younger employees.
- 7. What benefit do Special Needs Plans (SNPs) provide for enrollees with chronic conditions?**
- A. SNPs offer lower premiums compared to regular plans.
 - B. SNPs include specialized services and prescription drug coverage.
 - C. SNPs restrict access to certain healthcare providers.
 - D. SNPs are available only to low-income beneficiaries.
- 8. What determines if Mrs. Paterson is eligible for Medigap benefits?**
- A. Her age and whether she has previously been enrolled in Medicare
 - B. Coverage must align with the plans available in her state
 - C. She must be continuously enrolled in Original Medicare
 - D. All individuals over 65 can get Medigap plans regardless of Medicare status
- 9. Which statement is true about the formulary of a Medicare Part D plan?**
- A. It is required to cover all FDA-approved medications
 - B. It can vary significantly among different Part D plans
 - C. It must remain unchanged throughout the benefit year
 - D. It is not influenced by cost factors
- 10. What could be a consequence of not enrolling in a Part D plan during the initial eligibility period?**
- A. An increased premium penalty may apply
 - B. They will automatically be assigned to a standard plan
 - C. All future Medicaid eligibility will be lost
 - D. Enrollment will not be allowed until the next year

Answers

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

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Explanations

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1. What is the advantage of enrolling in a Medicare Advantage plan for Ms. Thomas?

- A. Decreased premiums
- B. Increased coverage options**
- C. Guaranteed acceptance
- D. Lower deductibles

Enrolling in a Medicare Advantage plan provides Ms. Thomas with increased coverage options, which is a significant advantage. Medicare Advantage plans, also known as Medicare Part C, often bundle various types of health insurance coverage, including hospital insurance (Part A), medical insurance (Part B), and sometimes additional benefits such as vision, dental, hearing, and wellness programs. This enhanced coverage can cater to a wide range of healthcare needs beyond what Original Medicare offers. With Medicare Advantage plans, Ms. Thomas could also have access to a broader network of healthcare providers and may benefit from coordinated care services that can simplify managing her health. Furthermore, these plans often include coverage for prescription drugs, which could be a considerable convenience for her healthcare management. This option stands out particularly because while some individuals might find lower premiums, guaranteed acceptance, or lower deductibles appealing, the comprehensive nature of coverage options available through Medicare Advantage means Mrs. Thomas could have a more tailored approach to her healthcare needs. It enhances her ability to choose services that align more closely with her lifestyle and healthcare goals.

2. What should you do upon discovering unreported discrepancies about enrollees in a monthly report?

- A. Ignore it as instructed by your supervisor
- B. Report it through your compliance department's anonymous tip line**
- C. Discuss it openly with other coworkers
- D. Document it and forget about it

Reporting unreported discrepancies about enrollees through your compliance department's anonymous tip line is essential to uphold ethical standards and regulatory compliance. This action promotes transparency and accountability within the organization. By using the anonymous tip line, you ensure that the discrepancies are addressed appropriately while also protecting yourself from potential backlash. It's critical to follow established protocols for reporting concerns related to fraud, waste, and abuse, as this contributes to the organization's integrity and the overall mission of delivering quality care and services. Options such as ignoring the issue or discussing it with coworkers undermine the seriousness of the findings and could perpetuate the problem rather than resolve it. Such actions fail to align with the obligations to report any suspicion of wrongdoing, risking compliance violations and potential harm to enrollees. Documenting the discrepancies and disregarding them also does not fulfill the responsibility of addressing issues that could impact beneficiary care and services. Thus, reporting through the compliance department's channels is the most responsible and ethical course of action.

3. What types of insurance products can be presented during a Medicare Advantage and Part D marketing appointment?

- A. Only health care related lines of business with permission**
- B. All types of insurance products available
- C. Only Medicare Advantage plans
- D. Only Medigap policies

The correct response indicates that during a Medicare Advantage and Part D marketing appointment, it is permissible to present only health care-related lines of business, and only with the explicit permission of the beneficiary. This is crucial because the regulations surrounding Medicare marketing are designed to protect beneficiaries from being overwhelmed or confused by offers unrelated to their Medicare coverage. In the context of the Medicare program, beneficiaries are already navigating a complex landscape. Allowing agents to present only relevant products ensures clarity and relevance, facilitating informed decision-making for the beneficiary. This restriction helps maintain compliance with Medicare's marketing regulations, which are intended to prevent misleading practices and promote a focus on the products specifically intended for their coverage under Medicare. In contrast, other options suggest a broader scope of products that can be presented, which is not aligned with the guidelines set forth for Medicare Advantage and Part D marketing. Presenting all types of insurance products could introduce unnecessary complexity and confusion for beneficiaries who may not be familiar with non-healthcare-related products. Limiting the discussion to health care-related items, along with obtaining permission, serves to protect the interests of beneficiaries and uphold the integrity of the Medicare program.

4. Who among Miles' clients qualifies for the opt-in simplified enrollment mechanism?

- A. Charles, who just turned 65.
- B. Adam and Betty, who have continuous coverage.**
- C. Diedre, who has coverage through another company.
- D. All clients qualify for the mechanism.

The opt-in simplified enrollment mechanism is designed for individuals who have a consistent history of health coverage, as it streamlines the enrollment process for them. In the case of Adam and Betty, their continuous coverage means they have maintained health insurance without significant gaps, which qualifies them for this mechanism. This is important because continuous coverage demonstrates stability in their health insurance status, making the enrollment process smoother and more efficient. For the other scenarios, such as Charles, who has just turned 65, this does not automatically qualify him for the simplified mechanism since it typically applies to those with established continuous coverage, and new beneficiaries may not have this history. Diedre, who holds coverage through another company, may also face different criteria that do not align with the opt-in mechanism unless her coverage history meets specific conditions under the regulations. Lastly, not all clients automatically qualify, as the mechanism is specifically tailored for those like Adam and Betty who demonstrate continuous coverage. Thus, identifying clients with maintained health insurance history is central to qualifying for this option.

5. Which practice can significantly contribute to identifying and preventing FWA?

- A. Conducting routine audits**
- B. Allowing unrestricted access to patient data
- C. Working independently without guidance
- D. Deferring decisions to third parties

Conducting routine audits is a critical practice in identifying and preventing fraud, waste, and abuse in healthcare. Audits help organizations systematically review their processes, claims, and billing practices to detect irregularities or discrepancies that may indicate fraudulent behavior. By regularly assessing various aspects of operations, healthcare providers can identify patterns of behavior that could suggest FWA, thereby allowing for timely interventions. Audits also foster accountability within the organization, ensuring that all personnel understand the importance of compliance and adherence to regulations. Furthermore, findings from audits can inform training programs and policies, enhancing overall awareness and reducing the likelihood of errors or intentional misconduct in the future. With this proactive approach, organizations not only safeguard their resources but also protect the integrity of healthcare delivery systems.

6. What happens to Juan Perez's employer-sponsored healthcare coverage when he enrolls in Medicare?

- A. Medicare becomes the secondary payor for his claims.
- B. He must choose between Medicare and employer coverage.
- C. Medicare becomes the primary payor for his healthcare claims.**
- D. His employer must continue to provide coverage comparable to younger employees.

When an individual like Juan Perez becomes eligible and enrolls in Medicare, the primary rule that determines how healthcare coverage works is based on his employer's size and the type of coverage provided. In many cases, when a person is covered by both Medicare and employer-sponsored health insurance, Medicare often acts as the primary payer if the employer has fewer than 20 employees. This means that Medicare will pay first for any healthcare claims, and the employer's plan may then cover some of the remaining costs. In the scenario where Juan is eligible for Medicare and still has employer coverage, if his employer has 20 or more employees, the employer insurance typically becomes the primary payor for claims, and Medicare acts as the secondary payor. However, in instances where the employer has less than 20 employees, Medicare is the primary payer. Understanding these dynamics is crucial because it affects how medical bills are paid and how much out-of-pocket expenses an individual may incur. Therefore, Juan's enrollment in Medicare can result in Medicare becoming the primary payor, especially if the employer's insurance plan is small. This context of the relationship between Medicare and employer-sponsored coverage clarifies why this option is the correct one in understanding how Juan's healthcare claims will be managed after he enrolls

7. What benefit do Special Needs Plans (SNPs) provide for enrollees with chronic conditions?

- A. SNPs offer lower premiums compared to regular plans.
- B. SNPs include specialized services and prescription drug coverage.**
- C. SNPs restrict access to certain healthcare providers.
- D. SNPs are available only to low-income beneficiaries.

Special Needs Plans (SNPs) are designed to cater specifically to individuals with chronic conditions, ensuring that they receive coordinated and tailored healthcare services. This includes specialized services that are essential for managing their specific health needs more effectively than what might be available through regular Medicare plans. The inclusion of comprehensive prescription drug coverage within SNPs further supports enrollees in managing their conditions by making necessary medications more accessible and affordable. The focus of SNPs on personalized care is crucial for those with chronic illnesses, as it helps address their unique health issues and circumstances. By streamlining their access to specialized services, these plans can lead to better health outcomes and a more comprehensive approach to patient care, which is vital for those with ongoing health challenges. The holistic support provided by SNPs enables enrollees to navigate the complexities of their healthcare more efficiently.

8. What determines if Mrs. Paterson is eligible for Medigap benefits?

- A. Her age and whether she has previously been enrolled in Medicare
- B. Coverage must align with the plans available in her state
- C. She must be continuously enrolled in Original Medicare**
- D. All individuals over 65 can get Medigap plans regardless of Medicare status

The eligibility for Medigap benefits primarily hinges on an individual being continuously enrolled in Original Medicare, which comprises Part A (Hospital Insurance) and Part B (Medical Insurance). Medigap policies are designed to supplement Original Medicare by covering costs that Medicare does not, such as copayments, coinsurance, and deductibles. Therefore, without enrollment in both parts of Medicare, an individual cannot obtain a Medigap plan, as these plans are specifically tailored for those who have Original Medicare coverage. Enrollment continuity is also crucial; if Mrs. Paterson were to lapse in her Medicare coverage, her eligibility for a Medigap plan could be compromised. Additionally, while factors such as age and state availability play a role in the broader context of Medigap insurance, the core requirement remains the need for continuous enrollment in Original Medicare itself for one to be eligible for Medigap benefits. This means that regardless of the specifics of a given state's offerings or Mrs. Paterson's age, she must maintain her Original Medicare enrollment status to qualify for Medigap.

9. Which statement is true about the formulary of a Medicare Part D plan?

- A. It is required to cover all FDA-approved medications
- B. It can vary significantly among different Part D plans**
- C. It must remain unchanged throughout the benefit year
- D. It is not influenced by cost factors

The correct statement about the formulary of a Medicare Part D plan is that it can vary significantly among different Part D plans. Each Medicare Part D plan has the flexibility to create its own formulary, which is a list of covered medications. This means that the specific drugs covered, as well as any restrictions or requirements related to their use (such as prior authorization, quantity limits, or step therapy), can differ widely from one plan to another. This variability allows plans to tailor their formularies based on various factors, including the needs of their beneficiaries and negotiations with drug manufacturers. Therefore, enrollees must carefully review the formulary of any plan they are considering to ensure that their necessary medications are included. The other statements do not accurately reflect the characteristics of Medicare Part D formularies. For instance, it is not required to cover all FDA-approved medications, as this would be impractical and financially unfeasible for many plans. Additionally, formularies may change during the benefit year to reflect new drugs, changes in drug prices, or changes in treatment guidelines. Finally, cost factors play a crucial role in formulary decisions since plans often consider the cost-effectiveness of medications when determining their coverage.

10. What could be a consequence of not enrolling in a Part D plan during the initial eligibility period?

- A. An increased premium penalty may apply**
- B. They will automatically be assigned to a standard plan
- C. All future Medicaid eligibility will be lost
- D. Enrollment will not be allowed until the next year

The consequences of not enrolling in a Part D plan during the initial eligibility period include an increased premium penalty that may apply when the individual eventually decides to enroll. This penalty is designed to encourage timely enrollment in a prescription drug plan to maintain a healthy insurance pool. If a person chooses to delay their enrollment, they may face higher costs because their monthly premiums can be increased by 1% for every month they went without coverage after becoming eligible. This penalty persists for as long as the individual remains enrolled in Part D, which can lead to significant financial implications over time. The other potential choices do not accurately reflect the primary consequence of missing the initial enrollment period. There is no automatic assignment to a plan, loss of future Medicaid eligibility, or a blanket prohibition against enrolling until the next year, as individuals have opportunities to enroll during special enrollment periods or during the annual enrollment period.

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.

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

<https://ahipfwa.examzify.com>

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

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