

AHIP Medicare Training Practice Exam (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 can Debbie do to assist her father in enrolling in MaxCare's Medicare Advantage plan?**
 - A. Submit a request without any legal authority**
 - B. Submit an enrollment request on Mr. Lee's behalf if she attests to her legal authority**
 - C. Enroll Mr. Lee without notifying the plan**
 - D. Ask a friend to help with the enrollment**

- 2. In what situation would a Medicare beneficiary receive home health care?**
 - A. When they are in need of cosmetic surgeries.**
 - B. When they are homebound and require skilled nursing or therapy services for a limited period.**
 - C. When they have an appointment for general check-ups.**
 - D. When they are undergoing a long-term rehabilitation program.**

- 3. How will Mr. Diaz be affected if he did not sign up for Part B when first eligible?**
 - A. He will pay a premium penalty**
 - B. He will not pay any penalty due to continuous coverage**
 - C. He must enroll in a Medicare Advantage plan immediately**
 - D. He can appeal for Special Enrollment**

- 4. How does Medicare determine its payment responsibilities with other insurances?**
 - A. Based on the beneficiary's age**
 - B. According to the type of coverage the beneficiary has**
 - C. Based on the hospital's billing practices**
 - D. According to the physician's recommendations**

- 5. What should you explain to hospital administration concerned about marketing in their facility?**
 - A. Marketing can only occur during patient hours**
 - B. Brochures can only be placed in treatment areas**
 - C. Marketing is acceptable in common areas**
 - D. All marketing must be approved by the health department**

- 6. What should Mrs. Roswell do if she can't find a Medicare Part D plan that covers all her medications?**
- A. Accept any new medications prescribed.**
 - B. Request that her existing drugs be covered during the transition period.**
 - C. Every Part D plan covers a one-month fill of her medications during a transition period.**
 - D. She must pay out-of-pocket for her medications until the coverage begins.**
- 7. During the appointment with Mrs. Lu, what are you allowed to provide her with?**
- A. General information about Medicare**
 - B. Required enrollment materials and her completed application**
 - C. Brochures from multiple companies**
 - D. Advice on medical services providers**
- 8. What conditions must be met for skilled nursing facility care coverage under Medicare?**
- A. The individual must have a qualifying hospital stay of at least three days**
 - B. The care must be available in their home**
 - C. The individual must be over the age of 65**
 - D. The care must be provided by a family member**
- 9. In most Medicare Advantage HMOs, what is required for Mr. Kumar to access healthcare providers?**
- A. He can visit any provider he chooses**
 - B. He must obtain services from contracted providers**
 - C. He can only receive emergency care from any provider**
 - D. He does not need any prior authorizations**

- 10. If Mr. Carlini prefers Original Medicare but wants prescription drug coverage, what can he do?**
- A. He must switch to a Medicare Advantage Plan.**
 - B. He can enroll in a standalone prescription drug plan offered through a private company.**
 - C. He is required to purchase both Original Medicare and a Medicare Advantage Plan.**
 - D. He cannot get drug coverage while on Original Medicare.**

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Answers

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

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Explanations

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1. What can Debbie do to assist her father in enrolling in MaxCare's Medicare Advantage plan?

- A. Submit a request without any legal authority**
- B. Submit an enrollment request on Mr. Lee's behalf if she attests to her legal authority**
- C. Enroll Mr. Lee without notifying the plan**
- D. Ask a friend to help with the enrollment**

The option indicating that Debbie can submit an enrollment request on her father's behalf if she attests to her legal authority is the correct choice. This is based on the regulations governing Medicare Advantage plans, which allow someone with legal authority—such as a power of attorney or a legal guardian—to act on behalf of another person when it comes to health plan enrollment. When a caregiver like Debbie takes on the responsibility of enrolling a family member in a Medicare Advantage plan, they must confirm that they have the necessary legal authority to perform such an action. Attesting to this authority ensures that the enrollment process is legitimate and compliant with regulations, protecting both the enrollee and the plan. This approach legitimizes Debbie's involvement in the process, ensuring that all documentation is appropriately handled and that MaxCare is informed of who is acting on Mr. Lee's behalf. The other options fail to meet the necessary criteria for responsible enrollment behavior or involve unsafe practices that could lead to complications in the enrollment process.

2. In what situation would a Medicare beneficiary receive home health care?

- A. When they are in need of cosmetic surgeries.**
- B. When they are homebound and require skilled nursing or therapy services for a limited period.**
- C. When they have an appointment for general check-ups.**
- D. When they are undergoing a long-term rehabilitation program.**

A Medicare beneficiary would receive home health care primarily when they are homebound and require skilled nursing or therapy services for a limited period. This is because Medicare provides coverage for home health services specifically to support individuals who are unable to leave their homes without considerable difficulty. To qualify for home health care, patients must have a physician's order and demonstrate a need for skilled nursing care or therapy services such as physical, occupational, or speech therapy. The focus is on providing necessary medical support and rehabilitation in a home setting to assist with recovery or management of health conditions. The other options describe situations that do not align with the criteria for home health care under Medicare. Cosmetic surgeries are not typically covered as home health services since they are elective and not medically necessary. General check-up appointments are usually conducted in a clinical or outpatient setting rather than at home, and long-term rehabilitation programs often require more extensive facilities and resources than what is available through home health services.

3. How will Mr. Diaz be affected if he did not sign up for Part B when first eligible?

- A. He will pay a premium penalty
- B. He will not pay any penalty due to continuous coverage**
- C. He must enroll in a Medicare Advantage plan immediately
- D. He can appeal for Special Enrollment

The choice indicating that Mr. Diaz will not pay any penalty due to continuous coverage is accurate in specific circumstances. When an individual is first eligible for Medicare, if they have credible health coverage through an employer or another source, they can delay signing up for Part B without incurring a penalty when they eventually enroll. This refers to continuous coverage, where the individual is protected from penalties due to their existing health insurance. However, it's essential to emphasize that this only applies if the coverage is deemed credible and consistent. If Mr. Diaz did not have continuous or credible coverage and missed the Part B enrollment window, he would typically face a premium penalty when he eventually enrolls, reflecting the relevance of understanding coverage eligibility nuances. For those who are unaware of the implications of delaying Part B enrollment without proper coverage might mistakenly think they are safe from penalties, underscoring the importance of knowing the specifics of Medicare enrollment periods and the conditions that apply. Understanding these distinctions helps navigate Medicare options more effectively.

4. How does Medicare determine its payment responsibilities with other insurances?

- A. Based on the beneficiary's age
- B. According to the type of coverage the beneficiary has**
- C. Based on the hospital's billing practices
- D. According to the physician's recommendations

Medicare determines its payment responsibilities with other insurances primarily according to the type of coverage that the beneficiary has. This means that if a Medicare beneficiary has additional coverage, such as employer-sponsored insurance or Medicaid, Medicare evaluates how these different insurance plans interact with each other to ensure that claims are processed correctly and efficiently. The primary insurance is responsible for paying first, followed by secondary insurances, which may cover remaining costs. This process helps to coordinate benefits and ensures that the beneficiary does not face excessive out-of-pocket expenses. Each type of coverage—whether it's Medicare, employer coverage, or other health insurance—follows specific rules for coordination of benefits, influencing how payments are allocated and who pays first based on the policyholder's situation. Understanding this framework is essential for anyone involved in Medicare or working alongside beneficiaries, as it directly impacts how health care costs are managed and shared between multiple insurance sources.

5. What should you explain to hospital administration concerned about marketing in their facility?
- A. Marketing can only occur during patient hours
 - B. Brochures can only be placed in treatment areas
 - C. Marketing is acceptable in common areas**
 - D. All marketing must be approved by the health department

Hospital administration may have concerns about marketing practices within their facility, particularly regarding compliance with regulations and maintaining a professional environment. Marketing in common areas is a widely accepted practice because these spaces are accessible to both patients and visitors, allowing hospitals to inform and educate about services without disrupting clinical activities. Marketing efforts in common areas can include placing informational brochures, posters, and digital displays that promote health services, upcoming events, or educational resources. This approach supports patient engagement and helps the hospital communicate its value while adhering to guidelines regarding professional conduct and patient privacy. In contrast, marketing that occurs during patient hours, or within treatment areas, could potentially interfere with patient care and lead to distractions for both medical staff and patients. Therefore, understanding that common areas provide an appropriate venue for promotional activities is crucial for hospital administration in navigating these concerns effectively.

6. What should Mrs. Roswell do if she can't find a Medicare Part D plan that covers all her medications?
- A. Accept any new medications prescribed.
 - B. Request that her existing drugs be covered during the transition period.
 - C. Every Part D plan covers a one-month fill of her medications during a transition period.**
 - D. She must pay out-of-pocket for her medications until the coverage begins.

The correct answer represents a key aspect of how Medicare Part D handles situations where beneficiaries transition into new plans. During a transition period, new enrollees typically have the right to receive a temporary supply of their medications even if the specific drugs aren't included in their new Part D plan's formulary. This is designed to ensure that beneficiaries do not experience gaps in their medication usage while they explore their options. While it's true that not all drugs will be covered under a new plan, the aim of the transition period is to provide immediate access to necessary medications. The concept behind this policy is to support patients during the potentially confusing and stressful transition into a new Part D plan, offering them time to review their medication needs and potentially switch plans if they find that their medications aren't being covered. In this context, other options lack the same support-oriented approach. Accepting any new medications prescribed or paying entirely out-of-pocket would not address the immediate need for medication continuity. Additionally, the notion that every Part D plan covers a one-month fill isn't entirely accurate, as coverage can vary by plan and the transition rules may not apply universally to all medications or situations. Thus, focusing on the temporary coverage available during a transition period is crucial for ensuring uninterrupted access to necessary medications.

7. During the appointment with Mrs. Lu, what are you allowed to provide her with?

- A. General information about Medicare**
- B. Required enrollment materials and her completed application**
- C. Brochures from multiple companies**
- D. Advice on medical services providers**

The correct option allows you to provide Mrs. Lu with required enrollment materials and her completed application. This is appropriate because it aligns with the regulations governing Medicare enrollment. During appointments, it's essential not only to furnish individuals with the necessary paperwork but also to ensure that they understand their options in the enrollment process. This facilitates a smoother transition into Medicare and provides them with the necessary information to make informed decisions regarding their coverage. Providing general information about Medicare is very helpful, but it does not equate to delivering the specific enrollment materials that Mrs. Lu may need to complete the process. Similarly, brochures from multiple companies may pose a risk as they could create confusion or be perceived as promoting certain plans over others, which may not be compliant with the guidelines. As for giving advice on medical service providers, this crosses into areas that could lead to conflicts of interest or liability, as it might suggest endorsement of particular services outside of the information strictly needed for Medicare enrollment. Thus, sharing the enrollment materials and application is the most straightforward and compliant action during this appointment.

8. What conditions must be met for skilled nursing facility care coverage under Medicare?

- A. The individual must have a qualifying hospital stay of at least three days**
- B. The care must be available in their home**
- C. The individual must be over the age of 65**
- D. The care must be provided by a family member**

The correct answer highlights an essential requirement for skilled nursing facility (SNF) care coverage under Medicare. Specifically, an individual must have a qualifying hospital stay of at least three days before being eligible for Medicare coverage for SNF care. This rule is in place to ensure that the need for skilled nursing services is based on a recent hospital admission, indicating that a patient's condition was serious enough to warrant hospitalization. This provision is crucial because it links the need for skilled care to a specific medical necessity, ensuring that patients who transition from a hospital to a skilled nursing facility are doing so for reasons that are medically justified and that will assist in their recovery process. It reflects Medicare's focus on providing care that is both necessary and appropriate. Other options do not fulfill the specific requirements for Medicare SNF coverage. For instance, receiving care at home or being over a certain age does not inherently determine eligibility for skilled nursing benefits, as these factors may not guarantee the level of skilled care needed. Similarly, coverage for care provided by family members often does not align with Medicare's rules, which typically requires professional healthcare providers to deliver such services in a skilled nursing facility.

9. In most Medicare Advantage HMOs, what is required for Mr. Kumar to access healthcare providers?

- A. He can visit any provider he chooses**
- B. He must obtain services from contracted providers**
- C. He can only receive emergency care from any provider**
- D. He does not need any prior authorizations**

In most Medicare Advantage HMOs, members are required to obtain services from contracted providers. This means that Mr. Kumar must seek care from healthcare providers that have an agreement with his Medicare Advantage HMO plan. The goal of this requirement is to manage costs and ensure coordinated care within the network. Medicare Advantage HMOs have designated networks of providers, and receiving services outside these contracted providers typically means the member will have to pay all costs associated with that care, except in emergencies. This model helps the plan manage resources effectively while providing members access to necessary healthcare services. The requirement to use contracted providers typically leads to more effective care coordination, as these providers are familiar with the benefits and coverage details of the HMO plan, helping to ensure that the care provided is in line with the plan's protocols.

10. If Mr. Carlini prefers Original Medicare but wants prescription drug coverage, what can he do?

- A. He must switch to a Medicare Advantage Plan.**
- B. He can enroll in a standalone prescription drug plan offered through a private company.**
- C. He is required to purchase both Original Medicare and a Medicare Advantage Plan.**
- D. He cannot get drug coverage while on Original Medicare.**

Mr. Carlini can indeed enroll in a standalone prescription drug plan offered through a private company if he prefers Original Medicare but still wants prescription drug coverage. This is a suitable option because Original Medicare (Parts A and B) does not include prescription drug coverage. By choosing to add a standalone plan, Mr. Carlini can maintain his Original Medicare enrollment while also receiving the necessary coverage for his prescription medications. This allows him flexibility in his healthcare choices, as he can select a drug plan that best suits his needs without having to switch to a Medicare Advantage Plan, which may have different provider networks and coverage rules.

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://ahipmedicaretraining.examzify.com>

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

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