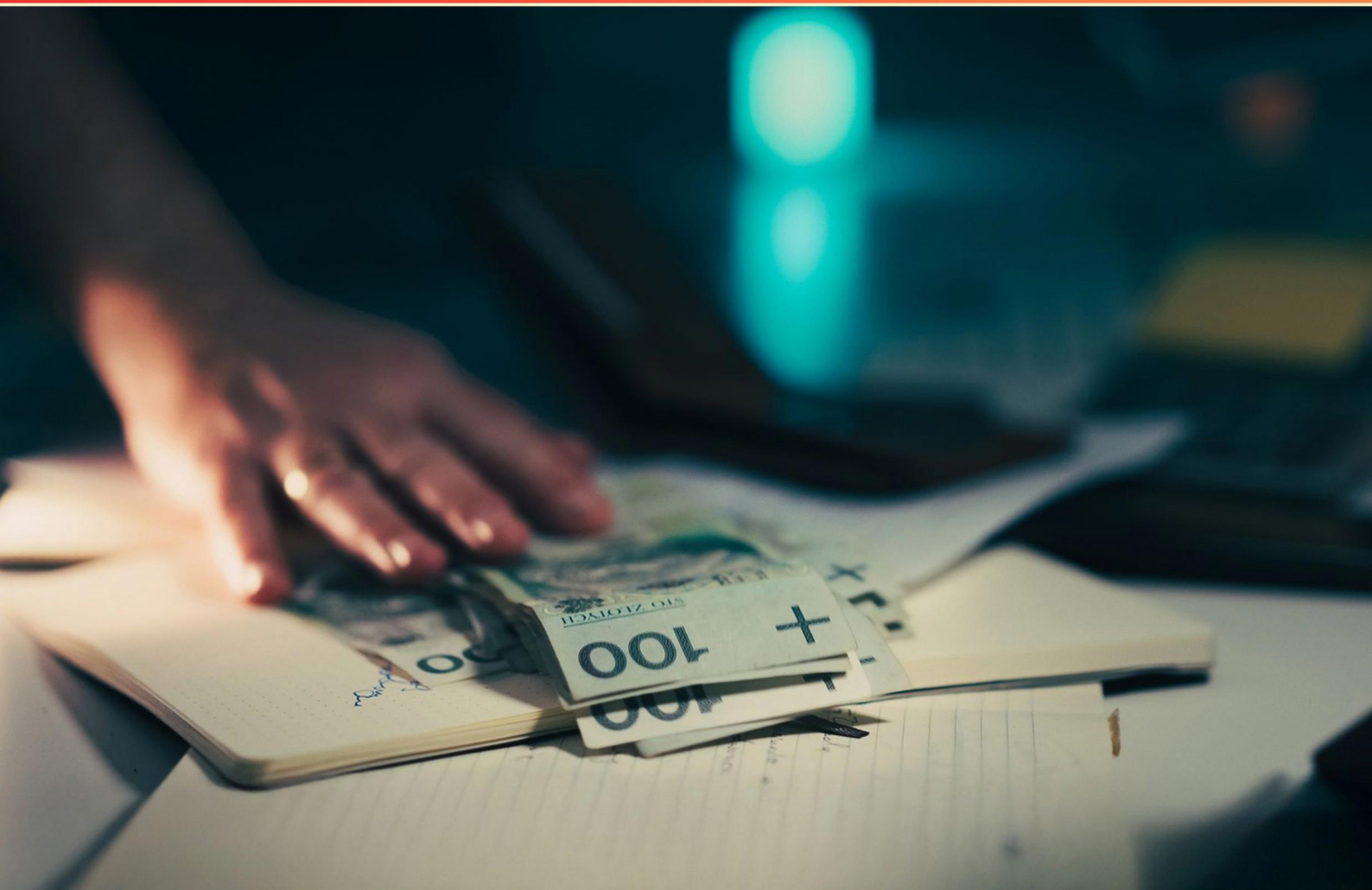


CMS-1500 CLAIM FORM PRACTICE TEST (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

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

<https://cms1500claimform.examzify.com>



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Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	15

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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. Block 24d has how many diagnosis reference numbers per line?**
 - A. Two
 - B. Four
 - C. One
 - D. Three

- 2. What is the likely outcome if the billing provider's NPI is missing on a CMS-1500 claim?**
 - A. The claim may be denied or delayed due to missing NPI.
 - B. The claim will automatically be paid.
 - C. The claim will be sent to the patient for payment.
 - D. The claim is canceled automatically.

- 3. What is the primary purpose of the CMS-1500 form?**
 - A. To collect patient payment at time of service.
 - B. To bill third-party payers for professional medical services provided to patients.
 - C. To document patient satisfaction surveys.
 - D. To authorize insurance coverage for experimental treatments.

- 4. Which statement best explains the purpose of listing multiple diagnoses on a CMS-1500 claim?**
 - A. To reflect the patient's mood during the visit.
 - B. To document all conditions that justify the service and support medical necessity and coding accuracy.
 - C. To shorten the claim processing time.
 - D. To record the service location.

- 5. Which of the following is a typical example of a place of service category on the CMS-1500?**
 - A. Office
 - B. Hospital
 - C. Clinic
 - D. All of the above

- 6. What is the primary use of the CMS-1500 claim form?**
- A. To bill hospital facility charges
 - B. To bill professional medical services provided by physicians and other healthcare providers to health plans/payers
 - C. To request patient refunds
 - D. To record experimental procedures
- 7. How are the two main sections of the CMS-1500 form distinguished, and what data does each contain?**
- A. Part I collects patient/insured demographic and policy information; Part II captures claim data such as dates of service, diagnosis codes, procedures, modifiers, charges, and provider information.
 - B. Part I handles claim data; Part II stores patient medical history.
 - C. Part I lists payer contact details; Part II handles appointment scheduling.
 - D. Part I summarizes patient outcomes; Part II tracks reimbursement timelines.
- 8. Which block is designated for writing the Coordination of Benefits Agreement Medigap-based identifier?**
- A. Block 9a
 - B. Block 9c
 - C. Block 11b
 - D. Block 10b
- 9. Block 28 is for secondary claims and records what?**
- A. The total amount the patient's primary insurance paid
 - B. Total charges for all services
 - C. The total amount the primary insurance paid
 - D. Leave blank
- 10. On CMS-1500 lines, what does the billed charge represent?**
- A. The amount billed by the provider
 - B. The payer's approved amount
 - C. The patient cost
 - D. The difference between promised and paid

Answers

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

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Explanations

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1. Block 24d has how many diagnosis reference numbers per line?

- A. Two
- B. Four
- C. One**
- D. Three

Block 24D is the Diagnosis Pointer field that links a service line to the diagnosis codes listed in Block 21. Up to four pointers can be placed per line, using the numbers 1 through 4 to indicate which diagnoses support the service. Each pointer matches the position of a diagnosis code in Block 21 (1 for the first code, 2 for the second, etc.). If only one diagnosis applies, you'd include just 1; if more apply, you can add additional pointers up to four. So per line, the maximum is four pointers.

2. What is the likely outcome if the billing provider's NPI is missing on a CMS-1500 claim?

- A. The claim may be denied or delayed due to missing NPI.**
- B. The claim will automatically be paid.
- C. The claim will be sent to the patient for payment.
- D. The claim is canceled automatically.

Missing the billing provider's NPI means the payer cannot identify who is billing, so the claim is typically denied or held for resubmission. The NPI is the unique identifier used to associate the claim with the correct provider and contract terms, so without it the claim can't be properly adjudicated. This isn't paid automatically, and it isn't automatically sent to the patient or canceled; the usual path is a denial or a request to resubmit with the correct NPI. To fix it, resubmit the claim with the billing provider's valid NPI in the appropriate place and ensure all required provider identifiers are present.

3. What is the primary purpose of the CMS-1500 form?

- A. To collect patient payment at time of service.
- B. To bill third-party payers for professional medical services provided to patients.**
- C. To document patient satisfaction surveys.
- D. To authorize insurance coverage for experimental treatments.

The main idea here is that the form is a standardized way to request payment from insurers for professional medical services. Providers fill it with the patient's and provider's details, the specific services rendered (using CPT/HCPCS codes), associated diagnoses (ICD-10-CM), dates of service, and charges. This allows third-party payers, including Medicare, Medicaid, and private insurers, to review, adjudicate, and reimburse for the professional care given. It isn't designed to collect patient payment at the time of service, document patient satisfaction surveys, or authorize coverage for experimental treatments. Those are separate processes outside the primary purpose of this claim form.

4. Which statement best explains the purpose of listing multiple diagnoses on a CMS-1500 claim?

- A. To reflect the patient's mood during the visit.
- B. To document all conditions that justify the service and support medical necessity and coding accuracy.**
- C. To shorten the claim processing time.
- D. To record the service location.

The main idea is that listing multiple diagnoses shows all conditions that justify the service and support medical necessity and coding accuracy. On a CMS-1500 claim, the ICD-10-CM codes tied to the encounter should reflect every active condition that contributed to the need for the evaluation or treatment. When you document all relevant diagnoses, you provide a complete clinical rationale for why the service was appropriate, which helps the payer determine coverage and ensures the coding matches the patient's actual health status. This reduces the chance of denials or requests for clarifications due to missing or incomplete justification, and it also helps ensure the CPT codes are paired with the correct diagnostic context. Solely noting the patient's mood, for example, would not establish why the medical service was needed. While aiming to speed up processing isn't the goal here, accurate and complete diagnosis documentation supports proper reimbursement and compliance with coding guidelines. Recording only the service location misses the medical reasons for the visit, which are captured by listing the diagnoses.

5. Which of the following is a typical example of a place of service category on the CMS-1500?

- A. Office
- B. Hospital
- C. Clinic
- D. All of the above**

The main idea here is that the CMS-1500 uses place of service codes to show where the service was provided, and those codes cover a variety of legitimate settings. Office, hospital, and clinic are all common locations where professional services can be rendered, so each one is a valid example of a place of service on the form. Because the claim needs to reflect the actual setting of the encounter, any of these settings could correctly appear as the place of service depending on where the patient received care. That's why the most accurate choice is that all of the above are typical examples. Misreporting POS can affect reimbursement and compliance, since payers differentiate pricing and rules based on the setting, so selecting the correct category matters for proper payment.

6. What is the primary use of the CMS-1500 claim form?

- A. To bill hospital facility charges
- B. To bill professional medical services provided by physicians and other healthcare providers to health plans/payers**
- C. To request patient refunds
- D. To record experimental procedures

The form is primarily used for billing professional medical services to payers. It's the standard document physicians and other non-institutional providers use to request payment for the clinical services they delivered, such as office visits, consultations, and procedures performed in their practice. On this form, you include patient details, provider information, dates of service, CPT/HCPCS procedure codes, ICD-10-CM diagnoses, and the associated charges. In contrast, charges for hospital facilities or inpatient services are billed on a different form (the UB-04) or institutional claim, and this form isn't for requesting patient refunds or recording experimental procedures. So the main purpose is to bill professional services to health plans and payers.

7. How are the two main sections of the CMS-1500 form distinguished, and what data does each contain?

- A. Part I collects patient/insured demographic and policy information; Part II captures claim data such as dates of service, diagnosis codes, procedures, modifiers, charges, and provider information.**
- B. Part I handles claim data; Part II stores patient medical history.
- C. Part I lists payer contact details; Part II handles appointment scheduling.
- D. Part I summarizes patient outcomes; Part II tracks reimbursement timelines.

The form is split into two sections by purpose: Part I is for identifying the patient and the insurer, while Part II is for the actual claim details about the services provided. In Part I you capture demographic and policy information—things like the patient's name, date of birth, address, and the insured's policy and group numbers. This section establishes who the patient is and who is responsible for payment or eligibility. In Part II you record the service-level data used to process the claim: dates of service, diagnosis codes, procedure codes (CPT/HCPCS), any modifiers, charges, and provider information. This is the information the payer uses to determine coverage and payment for the professional services rendered. So, Part I sets up identity and eligibility, while Part II details the actual medical services and billing items.

8. Which block is designated for writing the Coordination of Benefits Agreement Medigap-based identifier?

- A. Block 9a
- B. Block 9c**
- C. Block 11b
- D. Block 10b

Coordination of benefits information for a Medigap plan is captured in the area of the CMS-1500 form that holds data about another insured. Within that section, there are separate spaces for different types of identifiers. The specific space reserved for a Medigap COB identifier is the subfield designated for Coordination of Benefits. Entering the Medigap-based identifier here keeps it linked to the secondary coverage and allows payer systems to properly coordinate benefits with Medicare. Other data in that same area, such as the primary policy number or other insured details, belong in their own subfields, so using the coordination-of-benefits subfield avoids mixing different identifiers and supports accurate processing.

9. Block 28 is for secondary claims and records what?

- A. The total amount the patient's primary insurance paid**
- B. Total charges for all services
- C. The total amount the primary insurance paid
- D. Leave blank

Block 28 is used when a claim has a secondary payer. It records the amount that the primary insurance paid for the service. This lets the secondary payer know how much the primary plan contributed, so they can determine any remaining responsibility. For example, if the service charged \$200 and the primary insurer paid \$150, Block 28 would show 150. The secondary payer then uses that information to calculate its payment or the patient's remaining balance. Total charges and any blank status are handled in other parts of the form, and Block 28 is specifically about the primary payment amount for coordination of benefits.

10. On CMS-1500 lines, what does the billed charge represent?

- A. The amount billed by the provider**
- B. The payer's approved amount
- C. The patient cost
- D. The difference between promised and paid

On CMS-1500 lines, the billed charge represents the amount billed by the provider for the service. It's the price the clinician or facility asks for before any adjustments. This figure starts the claim processing, and later the payer may reduce it to an allowed amount, apply adjustments, and the patient may owe coinsurance or deductible. The other figures reflect what the payer actually pays or what's written off, not the original charge.

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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://cms1500claimform.examzify.com>

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

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