

COMPLETING THE UB-04 CLAIM FORM – INTRODUCTION PRACTICE TEST (SAMPLE) STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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. What are FL 35-36 Occurrence Span Codes & Dates used for?**
 - A. Events that would affect the billing/payment with a to and from date
 - B. Patient demographics
 - C. Diagnosis codes
 - D. Discharge status
- 2. HIPPS rate codes are used for payment determinations under several prospective payment systems. Which is an example of systems where HIPPS are used?**
 - A. Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, and Home Health Agencies
 - B. General acute care hospitals only
 - C. Outpatient clinics
 - D. Pharmacy benefit managers
- 3. Which data element in the header identifies the facility submitting the claim?**
 - A. Facility name and address
 - B. Diagnosis pointers
 - C. Payer information
 - D. Occurrence codes
- 4. What is the primary purpose of the Present on Admission (POA) field on the UB-04 form?**
 - A. To indicate whether a diagnosis was present at hospital admission.
 - B. To indicate the patient's preferred language.
 - C. To indicate the date of service.
 - D. To report the principal procedure.
- 5. Which field holds the country code used when services occur outside the United States?**
 - A. Birthdate field
 - B. Source of referral field
 - C. Country code field
 - D. DHR field

- 6. Which field records the total charges the provider expects to be paid?**
- A. Non-covered charges
 - B. Prior payments
 - C. Total charges
 - D. Health Plan ID
- 7. Which statement about the Document/Claim Control Number is true?**
- A. It identifies the patient
 - B. It indicates the service location
 - C. It is a unique claim track identifier used by the submitter
 - D. It records the date of service
- 8. How can you ensure the Principal Diagnosis aligns with the admission type?**
- A. Confirm that the principal diagnosis supports the reason for admission and matches the clinical scenario.
 - B. Choose the principal diagnosis randomly.
 - C. Only consider the most recent diagnosis.
 - D. It does not affect admission type.
- 9. Which field contains a narrative description or standard abbreviation for each revenue code category reported on this claim?**
- A. Revenue Codes
 - B. FL 43 Description
 - C. Inpatient revenue codes
 - D. 4 digit
- 10. How do you determine the correct beneficiary status for UB-04?**
- A. The patient's insurance coverage type and the encounter type determine beneficiary status; confirm with payer guidelines
 - B. The patient's age alone determines beneficiary status
 - C. The service location determines beneficiary status
 - D. The diagnosis code determines beneficiary status

Answers

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

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Explanations

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1. What are FL 35-36 Occurrence Span Codes & Dates used for?

A. Events that would affect the billing/payment with a to and from date

B. Patient demographics

C. Diagnosis codes

D. Discharge status

The main idea is that these fields capture events that can affect how a claim is paid, along with the time frame for those events. Occurrence span codes identify the type of event (for example, an accident, date of injury, onset of illness, or other qualifying incident), and the corresponding dates show when that event occurred, including the from-to period if it spans a range. Payers use this information to determine liability, coverage rules, and any special processing required for the claim. This helps explain why a claim might be paid differently or require additional documentation. These fields aren't about patient demographics, diagnosis codes, or discharge status; they specifically provide the timing of events that can influence billing.

2. HIPPS rate codes are used for payment determinations under several prospective payment systems. Which is an example of systems where HIPPS are used?

A. Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, and Home Health Agencies

B. General acute care hospitals only

C. Outpatient clinics

D. Pharmacy benefit managers

HIPPS codes are used to determine payment amounts under certain post-acute prospective payment systems. The correct example includes Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, and Home Health Agencies because these settings all use HIPPS-based PPS to establish payment rates based on patient characteristics and resource use. General acute care hospitals are paid with DRGs, not HIPPS; outpatient clinics rely on outpatient prospective payment methods or APCs rather than HIPPS; and pharmacy benefit managers operate in drug benefits rather than PPS payment systems. So, the settings listed are the ones where HIPPS rate codes drive payment determinations.

3. Which data element in the header identifies the facility submitting the claim?

A. Facility name and address

B. Diagnosis pointers

C. Payer information

D. Occurrence codes

The data element that identifies the facility submitting the claim is the facility name and address. In the UB-04 header, this field records who is filing the claim—the exact hospital or clinic submitting the form—so that the payer and involved providers know the source of the claim. Other header elements serve different purposes: payer information shows who is responsible for payment, not who submits; occurrence codes capture dates of events like admission or discharge; and diagnosis pointers link diagnoses to procedures. So the facility name and address is the piece that directly identifies the submitting institution.

4. What is the primary purpose of the Present on Admission (POA) field on the UB-04 form?

- A. To indicate whether a diagnosis was present at hospital admission.**
- B. To indicate the patient's preferred language.
- C. To indicate the date of service.
- D. To report the principal procedure.

The main idea here is to capture whether a diagnosis was already present when the patient was admitted to the hospital. The POA field marks each diagnosis as existing at admission or not, so clinicians and coders can distinguish pre existing conditions from those that developed during the stay. This distinction matters for quality reporting and reimbursement, because hospital acquired conditions and certain metrics may be handled differently depending on whether the condition was present on admission. It's not about the patient's language, the date of service, or reporting the principal procedure.

5. Which field holds the country code used when services occur outside the United States?

- A. Birthdate field
- B. Source of referral field
- C. Country code field**
- D. DHR field

When a claim includes services performed outside the United States, you need a field that specifically records the country where the service occurred. The country code field is the designated place on the UB-04 form to store that foreign country code, ensuring the claim is processed with the correct international billing rules and location context. The birthdate field is about the patient's date of birth, not service location. The source of referral field shows who referred the patient, not where the service happened. The DHR field carries other administrative or clinical data unrelated to the country of service.

6. Which field records the total charges the provider expects to be paid?

- A. Non-covered charges
- B. Prior payments
- C. Total charges**
- D. Health Plan ID

In UB-04 billing, you record the amount billed for the entire encounter in the total charges field. This is the gross amount the provider expects to be paid, serving as the baseline before any adjustments, discounts, or payer-specific write-offs are applied. Insurance payers use this figure to determine how much they will allow and what portion may be the patient's responsibility after benefits are applied. Non-covered charges refer to services not payable under the policy, and prior payments are amounts already paid toward the bill, while the Health Plan ID identifies the payer. None of these capture the initial billed amount as the total charges do.

7. Which statement about the Document/Claim Control Number is true?

- A. It identifies the patient
- B. It indicates the service location
- C. It is a unique claim track identifier used by the submitter**
- D. It records the date of service

Document/Claim Control Number serves as a unique tracking identifier created by the claim submitter to follow a specific claim through submission, processing, and adjudication. This number stays with the claim so the provider or payer can reference and reconcile it as it moves through the workflow. It isn't used to identify the patient, nor does it indicate the service location or the date of service—those details come from other fields. So, describing it as a unique claim track identifier used by the submitter is the accurate description.

8. How can you ensure the Principal Diagnosis aligns with the admission type?

- A. Confirm that the principal diagnosis supports the reason for admission and matches the clinical scenario.**
- B. Choose the principal diagnosis randomly.
- C. Only consider the most recent diagnosis.
- D. It does not affect admission type.

The principal diagnosis must reflect the reason the patient was admitted and justify the level of care described by the admission type. Since the admission type (inpatient, observation, etc.) is driven by the expected intensity and duration of services, the principal diagnosis should be the condition that actually occasioned the admission and requires that level of care, matching the clinical scenario documented by the physician. To ensure this alignment, review the admission note and initial assessment to identify the main problem that prompted admission, verify that the diagnosis code matches that problem, and confirm the care plan during the stay supports treating that condition. This consistency is essential for accurate coding and appropriate payment. Choosing a random diagnosis or focusing only on the most recent diagnosis would not reflect why the patient was admitted, and stating that the admission type is unaffected by the principal diagnosis is incorrect.

9. Which field contains a narrative description or standard abbreviation for each revenue code category reported on this claim?

- A. Revenue Codes
- B. FL 43 Description**
- C. Inpatient revenue codes
- D. 4 digit

Describing what each revenue code means is done in a dedicated text field. The field labeled Description (field 43) is the place to put a narrative description or a standard abbreviation for the revenue code category reported on the claim. This text helps reviewers quickly understand what the coded revenue code represents without having to memorize every code. The numeric revenue code itself is entered in the revenue code field, not in the description field. The other options don't provide a text description field for the codes.

10. How do you determine the correct beneficiary status for UB-04?

- A. The patient's insurance coverage type and the encounter type determine beneficiary status; confirm with payer guidelines**
- B. The patient's age alone determines beneficiary status
- C. The service location determines beneficiary status
- D. The diagnosis code determines beneficiary status

The main idea here is that beneficiary status on a UB-04 claim is determined by how the payer rules apply to the specific insurance coverage and the type of encounter, not by the patient's age, where the service was provided, or the diagnosis. Insurance coverage type tells you who the payer considers the beneficiary for this claim—whether the patient is the insured, a dependent, or another person covered under a plan. The encounter type (inpatient vs outpatient, for example) can change how payers apply benefits, coordination of benefits, and which payer is primary. Because these factors come from the payer's policies, you must check the payer guidelines and the patient's eligibility to assign the correct beneficiary status on the claim. Age, service location, and the diagnosis code don't determine beneficiary status. Age may influence eligibility in some contexts, but it doesn't define who the plan considers the beneficiary. The service location affects billing rules and coverage in some ways, but not who is the beneficiary. Diagnosis codes describe clinical conditions and medical necessity, not payer eligibility or beneficiary identity. So, confirming beneficiary status hinges on the payer's rules tied to the actual coverage type and the encounter type, using the patient's eligibility and payer guidelines as your guide.

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://completingtheub04claimformintro.examzify.com>

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

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