

Epic Claims and Remit 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. Which statement about ABF and FDF is true regarding Epic claim form customization?**
 - A. Much of the customization is accomplished through ABF and FDF**
 - B. It uses only ANSI files for customization**
 - C. It relies on external software outside Epic**
 - D. It does not affect form layouts**

- 2. What happens when a claim is sent to Medicare regarding the secondary payer?**
 - A. Medicare denies the claim**
 - B. Medicare forwards the claim to the secondary payer**
 - C. Medicare forwards the claim to the primary payer**
 - D. Medicare closes the claim without action**

- 3. A self-pay RMO allows you to automate posting self pay payments via a flat file from your ____.**
 - A. bank**
 - B. vendor**
 - C. payer**
 - D. customer**

- 4. In the HB work queue configuration, rules may appear as warning rules or error rules but are still considered what?**
 - A. Rule Sets**
 - B. HBW Rules**
 - C. Workque Rules**
 - D. Routing Rules**

- 5. Which of the following describes how a scenario can override RMC actions?**
 - A. Extension or rule record**
 - B. Remark or RMC**
 - C. Loading or accepting**
 - D. Subpayer or bank**

- 6. After mapping to ANSI standard codes for a new payer code, what should you do next?**
- A. Reload remit file**
 - B. Archive file**
 - C. Notify payer**
 - D. Ignore**
- 7. In Epic's data model for reimbursements, payer status information is stored in which bucket?**
- A. inventory bucket**
 - B. payments bucket**
 - C. insurance bucket**
 - D. claims bucket**
- 8. Remittance code mapping levels include plan, payer, and service area. Which complete list best describes this capability?**
- A. Plan, Payer, and Service Area**
 - B. Plan and Payer only**
 - C. Service Area only**
 - D. All options are false**
- 9. Use the ____ of the claim to test it against the Work Queue or rules used in the WQ. Which attribute is correct?**
- A. CLAIM NUMBER**
 - B. CLP ID**
 - C. PATIENT ID**
 - D. INVOICE ID**
- 10. Tables can reference an ID Type from ID maintenance to convert the bank's payer ID to the payer record in Epic.**
- A. ID Type**
 - B. Payer Type**
 - C. Bank Type**
 - D. Record Type**

Answers

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

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Explanations

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1. Which statement about ABF and FDF is true regarding Epic claim form customization?

- A. Much of the customization is accomplished through ABF and FDF**
- B. It uses only ANSI files for customization**
- C. It relies on external software outside Epic**
- D. It does not affect form layouts**

In Epic, most claim form customization is done directly through built-in form tools, specifically ABF and FDF. ABF (Adaptive Form Builder) handles how data is gathered, mapped, and logic-driven—determining which fields appear, where data sources feed the form, and under what conditions certain information shows up. FDF (Form Definition File) controls the physical layout of the form—where each field sits on the page, its size, font, and overall formatting. Using these together lets a clinic or payer tailor each claim form to meet requirements, update layouts as needs change, and do so within Epic’s environment. This isn’t about ANSI files, which relate to data interchange formats for claims rather than how the form looks or what data it includes. External software isn’t required because ABF and FDF are Epic’s built-in tools for customization. And because their purpose is to define both data and presentation on the form, they do affect form layouts—the very thing you’re customizing.

2. What happens when a claim is sent to Medicare regarding the secondary payer?

- A. Medicare denies the claim**
- B. Medicare forwards the claim to the secondary payer**
- C. Medicare forwards the claim to the primary payer**
- D. Medicare closes the claim without action**

When a claim involves Medicare as part of a secondary payer arrangement, the process is about coordinating benefits with the other payer that has the primary responsibility. In this setup, Medicare does not determine payment in isolation; instead, it passes the claim on to the other payer (the primary payer) so that that payer can adjudicate first and determine any remaining liability. After the primary payer has processed, Medicare can then review what, if anything, is left to pay as the secondary payer. This coordination ensures the correct order of payment and prevents double payment or gaps. So the correct action is that Medicare forwards the claim to the other payer to coordinate benefits. The alternatives—denying the claim outright, forwarding to the primary payer, or closing the claim without action—do not reflect how Medicare coordinate-of-benefits procedures work in MSP scenarios.

3. A self-pay RMO allows you to automate posting self pay payments via a flat file from your ____.

- A. bank**
- B. vendor**
- C. payer**
- D. customer**

Automating self-pay postings relies on data delivered by your bank. The bank (often through a lockbox or ACH process) processes patient payments and provides a flat file with the payment details, enough to map each payment to the correct patient account. The self-pay RMO uses that bank file to automatically apply cash, reducing manual entry and reconciliation. A vendor, payer, or customer isn't the typical upstream source for this self-pay posting workflow—the bank is.

4. In the HB work queue configuration, rules may appear as warning rules or error rules but are still considered what?

- A. Rule Sets**
- B. HBW Rules**
- C. Workqueue Rules**
- D. Routing Rules**

Rules in the HB work queue are evaluated by the system and can be flagged as warnings or errors, but they are still considered work queue rules. The severity (warning versus error) simply indicates how strictly the rule must be enforced or how it influences processing, not a different category of rule. Both types are part of the same rule set that governs how items flow through the work queue. For example, a rule might check for a missing field and trigger an error if strict handling is required, or a warning if processing can continue with a note. Either way, it remains a work queue rule.

5. Which of the following describes how a scenario can override RMC actions?

- A. Extension or rule record**
- B. Remark or RMC**
- C. Loading or accepting**
- D. Subpayer or bank**

Scenarios in RMC define when certain remittance rules should apply. To change what the system does in a given scenario, you use an extension or a rule record attached to that scenario. This extension or rule record introduces new logic or overrides existing actions, allowing you to tailor the processing for that specific case. In other words, extensions and rule records are the mechanisms that modify or override the default RMC actions for a scenario. Remarks or RMC concepts don't provide an override mechanism themselves; they're related elements like notes or the rule engine, but they don't change the behavior. Loading or accepting describe steps in processing, not how to override actions. Subpayer or bank refer to entities involved in the transaction, not the override mechanism.

6. After mapping to ANSI standard codes for a new payer code, what should you do next?

A. Reload remit file

B. Archive file

C. Notify payer

D. Ignore

After you map to ANSI standard codes for a new payer, you need to reload the remit file. Reloading applies the updated mappings so the system uses the new payer codes in future remit processing and adjudication. Without reloading, the system would still operate with the old mappings, which can cause unknown payer codes, misinterpretation of remits, and potential claim rejections. Archiving the file would remove the data you need for auditing and ongoing processing, notifying the payer is a separate communication step, and ignoring the update leaves the mapping stale. Reloading the remit file ensures the changes take effect and claims flow smoothly with the correct payer information.

7. In Epic's data model for reimbursements, payer status information is stored in which bucket?

A. inventory bucket

B. payments bucket

C. insurance bucket

D. claims bucket

Understanding where payer status information lives in Epic's data model is about organizing data by the domain it describes. Payer status refers to the relationship and responsibility of the payer in the reimbursement process—things like who is primary, secondary, or tertiary and how the insurer is involved in paying a claim. That kind of information is inherently tied to the patient's insurance coverage and the payer's role, so it belongs in the insurance data domain. In Epic, the insurance bucket is the place that houses data about policy details, eligibility, and payer relationships. This makes it the logical home for payer status, because it directly informs who should be billed first and how benefits should be coordinated. The other buckets serve different purposes. The inventory bucket is for stocked items and materials, not payer information. The payments bucket holds actual payment transactions, which occur after payer determination. The claims bucket contains the claims themselves, including the services billed and the outcomes, but not the payer role metadata itself. Keeping payer status in the insurance bucket ensures the reimbursement workflow can correctly apply coverage rules and adjudication logic.

8. Remittance code mapping levels include plan, payer, and service area. Which complete list best describes this capability?

A. Plan, Payer, and Service Area

B. Plan and Payer only

C. Service Area only

D. All options are false

Remittance code mapping uses three levels—plan, payer, and service area. Each level captures a different attribute that can affect how codes map to payments, because the same remittance code might be valid or have a different meaning depending on the benefit plan design, the insurer or payer responsible, and the geographic or service context where the service occurred. So the complete capability describes all three levels together: plan, payer, and service area. If you tried to describe it with fewer levels, you'd miss how the code should behave across one of these dimensions, leading to incomplete or incorrect mapping. The option that claims all other options are false is incorrect because the full, accurate description includes all three levels.

9. Use the ____ of the claim to test it against the Work Queue or rules used in the WQ. Which attribute is correct?

A. CLAIM NUMBER

B. CLP ID

C. PATIENT ID

D. INVOICE ID

The Work Queue's rules are mapped to the claim processing logic, identified by the CLP ID. This ID tells the system which set of validation and routing rules to apply to the claim, so testing the claim against the Work Queue should use the CLP ID to ensure you're checking the exact processing path the claim will follow. A claim number identifies a specific claim, but not which rules apply. A patient ID identifies the patient, not the processing workflow. An invoice ID relates to billing documents, not the claim's routing logic.

10. Tables can reference an ID Type from ID maintenance to convert the bank's payer ID to the payer record in Epic.

A. ID Type

B. Payer Type

C. Bank Type

D. Record Type

Understanding how Epic maps external identifiers to internal records is key here. ID Type in ID maintenance defines the kind of identifier you're dealing with and how that identifier should be interpreted when linking to Epic data. In this scenario, the table uses an ID Type to recognize the bank's payer ID as an external identifier and to map it to the corresponding internal payer record. That mapping is what allows Epic to translate the bank's payer ID into the payer record it uses internally. The other concepts don't fit this specific role. Payer Type categorizes payers, but doesn't drive the lookup from an external ID to a payer record. Bank Type would refer to categories of banks, not to how IDs map to records. Record Type relates to the kind of data record, not to the identifier mapping process.

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://epicclaimsremit.examzify.com>

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

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