

EPIC RESOLUTE PROFESSIONAL BILLING (PB) FUNDAMENTALS FOR SINGLE BILLING OFFICE PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE

<https://pbsinglebillingoffice.examzify.com>



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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. How does transactional history benefit billing offices?

- A. By speeding up claim approvals
- B. By providing a complete financial activity record
- C. By ensuring compliance with regulations
- D. By generating patient reports

2. What are charge sessions in the context of billing?

- A. Records of total payments received from patients
- B. Individual tickets for various visits
- C. Summaries of patient account statements
- D. Reports on overall billing efficiency

3. What is an 'outstanding balance' in a patient account?

- A. The amount still owed by the patient after payments and adjustments are made
- B. The total amount billed to the patient
- C. Funds available for credit from the patient
- D. The sum of unapproved claims

4. What do 'claim type codes' indicate in Epic Resolute?

- A. The payment methods accepted by the practice
- B. The type of patient insurance coverage
- C. The nature of the claim being submitted
- D. The urgency of the claim processing

5. In Epic Resolute, what is crucial for submitting accurate claims?

- A. Utilizing generic claim forms
- B. Ensuring correct claimant information and codes
- C. Conducting regular patient interviews
- D. Limiting claims to only a few services

- 6. How are remittances important in the billing process?**
- A. They indicate payments received from payers, affecting the patient account balance
 - B. They are used to generate new billing rules
 - C. They represent potential future charges
 - D. They are administrative costs to the billing office
- 7. Which statement accurately describes the role of the guarantor in account maintenance?**
- A. It focuses exclusively on the patient
 - B. It involves both patient and insurance details
 - C. It is primarily concerned with billing
 - D. It encompasses guarantor focused account oversight
- 8. What is the role of a charge ticket in billing?**
- A. A summary of all charges across multiple visits
 - B. A record of what was performed during a visit, including diagnoses and procedures
 - C. A document for patient collections only
 - D. A record of payments received during a billing session
- 9. What do EOB codes indicate in the claims process?**
- A. Eligibility of the patient for services
 - B. Status or action taken on a claim
 - C. Procedures to follow for denied claims
 - D. Payment policies of the provider
- 10. What is the role of the claims queue?**
- A. To hold transactions ready for billing
 - B. To generate report summaries
 - C. To provide a history of patient charges
 - D. To validate claim submissions

Answers

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

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Explanations

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1. How does transactional history benefit billing offices?

- A. By speeding up claim approvals
- B. By providing a complete financial activity record**
- C. By ensuring compliance with regulations
- D. By generating patient reports

The value of transactional history in billing offices lies in its capability to deliver a complete financial activity record. This comprehensive record includes all individual transactions related to a patient's billing profile, such as services rendered, payments received, and adjustments made. Having access to this detailed transactional history enables billing staff to track financial interactions effectively, ensuring they have a clear understanding of each patient's account status. This clarity is crucial for resolving discrepancies, managing collections, and performing reconciliations. Furthermore, a complete record can facilitate audits and enhance overall financial management, which is essential for maintaining the health of the billing office and ensuring accurate reporting. In contrast, while the other options touch upon valid aspects of billing operations, they do not encapsulate the primary benefit of transactional history as thoroughly as the complete financial activity record does. For example, speeding up claim approvals and generating patient reports are important, but they stem from the underlying availability of accurate data that is reflected in the transactional history. Similarly, ensuring compliance with regulations relates more to regulatory practices than the direct advantages of having a robust transactional history.

2. What are charge sessions in the context of billing?

- A. Records of total payments received from patients
- B. Individual tickets for various visits**
- C. Summaries of patient account statements
- D. Reports on overall billing efficiency

Charge sessions refer to the individual tickets or records created for various visits a patient has to a healthcare provider. Each charge session documents the services rendered, the associated charges, and pertinent details related to that specific appointment or encounter. This data is essential for billing purposes as it plays a crucial role in the preparation of claims submitted to insurers and ensures that providers can accurately capture the revenue due for services provided. These sessions help the billing department to track and manage the services rendered over time, providing a clear and organized way to process payments and manage accounts receivable. Each session acts as an integral unit of billing information, facilitating the overall functionality of the billing cycle by ensuring meticulous documentation of each patient interaction.

3. What is an 'outstanding balance' in a patient account?

- A. The amount still owed by the patient after payments and adjustments are made**
- B. The total amount billed to the patient
- C. Funds available for credit from the patient
- D. The sum of unapproved claims

An outstanding balance in a patient account refers specifically to the amount that remains unpaid by the patient after all payments and adjustments have been accounted for. This figure is crucial for financial tracking, as it directly reflects the patient's remaining financial obligation to the healthcare provider. When a patient receives treatment, several transactions can occur—insurance payments, discounts, or write-offs may all serve to reduce the initial charges. The outstanding balance represents what is left over once these adjustments are applied. This concept is essential for both patients and billing departments, as it indicates what still needs to be collected to settle the account fully. In contrast, the total amount billed is a broader figure that includes all charges before any payments or adjustments. Credit funds refer to amounts that could potentially be reimbursed back to the patient, and unapproved claims represent claims that have yet to be processed or accepted by the insurance and do not directly relate to what the patient owes. The definition of outstanding balance encapsulates the financial reality for patients and providers in the billing cycle.

4. What do 'claim type codes' indicate in Epic Resolute?

- A. The payment methods accepted by the practice
- B. The type of patient insurance coverage
- C. The nature of the claim being submitted**
- D. The urgency of the claim processing

Claim type codes in Epic Resolute indicate the nature of the claim being submitted. These codes are essential for identifying the specific type of service or treatment provided, which helps categorize the claim appropriately for processing and reimbursement. By specifying the claim type, these codes allow for streamlined handling of different claim situations, such as those related to inpatient versus outpatient services, or specialty care versus general practice. This categorization aids billing staff, insurers, and other stakeholders in understanding how to process the claim accurately and swiftly. It is crucial for ensuring that the claim aligns with the services rendered and helps in avoiding denials or delays in payment. Understanding the correct claim type codes is fundamental for efficient billing and revenue cycle management in a practice.

5. In Epic Resolute, what is crucial for submitting accurate claims?

- A. Utilizing generic claim forms
- B. Ensuring correct claimant information and codes**
- C. Conducting regular patient interviews
- D. Limiting claims to only a few services

In Epic Resolute, ensuring correct claimant information and codes is critical for submitting accurate claims because accurate data directly impacts the claim's validity and the likelihood of approval by payers. The information submitted must reflect the specifics of the services provided, including the correct patient demographics, provider details, diagnosis codes, and procedure codes. This not only helps in facilitating a smooth claims process but also reduces the chances of denials or delays in payment, which can significantly affect revenue flow for the practice. Furthermore, precise coding is necessary to comply with regulations and payer requirements. If the codes or information are incorrect, it can lead to claim rejections, necessitating resubmission and potentially delaying payment. Therefore, focusing on the accuracy of claimant information and codes is paramount for the efficiency and effectiveness of the billing process in any healthcare setting.

6. How are remittances important in the billing process?

- A. They indicate payments received from payers, affecting the patient account balance**
- B. They are used to generate new billing rules
- C. They represent potential future charges
- D. They are administrative costs to the billing office

Remittances play a crucial role in the billing process by indicating payments received from payers, which directly impacts the patient account balance. When a healthcare provider submits a claim to an insurance payer, the payer processes this claim and, upon approval, issues a remittance advice detailing the payment amount and any adjustments made. This information is vital as it allows the billing office to update the patient's account accurately, reflecting any payments made and remaining balances due. Understanding and applying remittance information ensures efficient accounts receivable management and helps maintain the financial health of the practice.

7. Which statement accurately describes the role of the guarantor in account maintenance?

- A. It focuses exclusively on the patient
- B. It involves both patient and insurance details
- C. It is primarily concerned with billing
- D. It encompasses guarantor focused account oversight**

The role of the guarantor in account maintenance is accurately reflected by the notion of guarantor-focused account oversight. In the context of medical billing and accounts, the guarantor is the individual responsible for the payment of a patient's medical bills. This role extends beyond merely being a contact point for billing purposes; it involves managing and overseeing all aspects associated with the account. Guarantor-focused account oversight means that the guarantor not only receives billing information but also plays an active role in ensuring that the account is correctly maintained, payments are made on time, and that any issues regarding the account, such as discrepancies or adjustments, are addressed promptly. This oversight includes keeping track of any changes in insurance information, billing addresses, or payment methods. This comprehensive approach demonstrates the critical nature of the guarantor's role in the overall financial management of the patient's account, highlighting the importance of having accurate and complete information for both efficient billing practices and improved patient experience. The involvement of the guarantor helps streamline communication and resolution of financial matters related to medical care, reinforcing the importance of maintaining solid oversight in the revenue cycle.

8. What is the role of a charge ticket in billing?

- A. A summary of all charges across multiple visits
- B. A record of what was performed during a visit, including diagnoses and procedures**
- C. A document for patient collections only
- D. A record of payments received during a billing session

The role of a charge ticket in billing is fundamentally to serve as a record of what was performed during a visit, including diagnoses and procedures. This document is critical as it captures essential information about the medical services provided to the patient during that particular visit. It includes details such as the specific procedures performed, any treatments administered, and diagnoses made by the healthcare provider. By documenting this information accurately, the charge ticket ensures that the billing department can subsequently generate invoices that reflect the true nature of the services rendered. This accurate record is essential for appropriate coding, which directly relates to the reimbursement process from insurance providers or patients. In contrast, other options do not capture the primary focus of a charge ticket. For instance, while a summary of charges across multiple visits serves a different function, it does not reflect the specifics of a single visit. Similarly, a document strictly for patient collections does not fulfill the role of documenting the services rendered. Lastly, a record of payments received pertains to the financial transaction aspect and does not encompass the clinical details of services provided during a visit.

9. What do EOB codes indicate in the claims process?

- A. Eligibility of the patient for services
- B. Status or action taken on a claim**
- C. Procedures to follow for denied claims
- D. Payment policies of the provider

EOB codes, or Explanation of Benefits codes, play a crucial role in the claims process by indicating the status or action taken on a claim. When a claim is processed by a payer, the EOB is generated to inform the healthcare provider and the patient about the outcome of that claim. It details whether the claim was approved or denied, the amount covered by insurance, any patient responsibility (like deductibles or co-pays), and any adjustments made to the billed amount. This serves as a communication tool that outlines the financial and procedural aspects of the claim, ensuring transparency between the provider, the patient, and the insurance company. Understanding EOB codes is essential for billing professionals, as they help interpret the outcome of claims and guide subsequent actions, such as resubmitting claims or communicating with patients about their balances. The other options do not accurately reflect the primary purpose of EOB codes. For instance, eligibility of the patient for services pertains to pre-authorization rather than the claim's outcome. Similarly, while procedures for denied claims are significant, they are not what EOB codes themselves indicate. Payment policies may influence reimbursement but are not explicitly represented by EOB codes. Therefore, B is the most accurate choice regarding the role EOB codes play in

10. What is the role of the claims queue?

- A. To hold transactions ready for billing
- B. To generate report summaries
- C. To provide a history of patient charges
- D. To validate claim submissions

The claims queue is primarily designed to hold transactions that are ready for billing. This functionality ensures that all claims are properly organized and accessible for billing staff to review and submit. By holding these transactions, the claims queue helps streamline the billing process, allowing healthcare providers to manage and process claims efficiently, ensuring they are submitted on time for reimbursement. This organizational role is critical in maintaining a smooth workflow within a billing office, as it enables teams to focus on completing the necessary steps for billing without losing track of any transactions. It also helps in quickly identifying and addressing any issues that may arise before final submission, ultimately contributing to effective revenue cycle management. The other options, while relevant to various aspects of the billing process, do not accurately describe the primary purpose of the claims queue. For instance, generating report summaries, providing a history of patient charges, and validating claim submissions are all important functions but serve different roles within the broader context of billing and revenue cycle management.

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://pbsinglebillingoffice.examzify.com>

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

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