

Epic Resolute Professional Billing (PB) Fundamentals 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

- 1. True or False: A batch must balance before you can successfully process it.**
 - A. True**
 - B. False**
 - C. Only for large batches**
 - D. Depends on the type of transaction**
- 2. What is a Guarantor in the context of patient billing?**
 - A. A provider responsible for collecting payments**
 - B. A person/entity financially responsible for the patient's account**
 - C. A system for tracking patient appointments**
 - D. A database of patient insurance information**
- 3. What captures every coverage a patient has ever had?**
 - A. Patient Filing Order**
 - B. Guarantor Account**
 - C. Hospital Account Record**
 - D. Enterprise Registration**
- 4. What does the three-letter abbreviation known as an INI refer to in the context of a master file?**
 - A. Individual Numeric Identifier**
 - B. Integrated Network Information**
 - C. Internal Name Identifier**
 - D. Instrumentation Number Index**
- 5. What does the term 'DNB' refer to in an HB HAR context?**
 - A. Does Not Bill**
 - B. Data Not Billed**
 - C. Delivered Not Billed**
 - D. Direction Not Billed**

- 6. Which action is NOT typically required to make a coverage effective for past encounters?**
- A. Undo billing for the HAR**
 - B. Add the coverage in Registration**
 - C. Notify the insurance provider**
 - D. Document the reason for the lack of coverage**
- 7. What do Master Files hold information about?**
- A. Financial transactions**
 - B. Insurance coverage**
 - C. Particular types of data**
 - D. Patient medical history**
- 8. Where can you identify the currently responsible payer from the storyboard?**
- A. Visit coverages sections**
 - B. Access the claims history**
 - C. Check the payment section**
 - D. Review the billing summary**
- 9. True or False: Refunds can be issued for payments collected at the front desk on the same day.**
- A. True**
 - B. False**
 - C. Only with managerial approval**
 - D. Depends on system settings**
- 10. Which of the following is a common reason for claim denials?**
- A. Incorrect patient information**
 - B. Uncommon medical procedures**
 - C. Lack of electronic records**
 - D. High patient volumes**

Answers

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

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Explanations

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1. True or False: A batch must balance before you can successfully process it.

A. True

B. False

C. Only for large batches

D. Depends on the type of transaction

A batch must indeed balance before it can be successfully processed. In the context of professional billing, balancing a batch means that the total debits and credits must match. This ensures that all financial transactions are accounted for accurately and helps maintain the integrity of financial records. If a batch is unbalanced, it indicates potential errors or discrepancies in the transactions included, which could lead to financial reporting issues or losses. Balancing is a critical step in the billing cycle as it not only affects the processing of the current batch but can also impact subsequent transactions and reports. Therefore, adherence to this requirement is essential for maintaining proper financial practices and ensuring compliance with regulatory standards.

2. What is a Guarantor in the context of patient billing?

A. A provider responsible for collecting payments

B. A person/entity financially responsible for the patient's account

C. A system for tracking patient appointments

D. A database of patient insurance information

In the context of patient billing, a guarantor is identified as the person or entity that is financially responsible for the patient's account. This means that the guarantor is accountable for paying the medical bills incurred by the patient. Understanding the role of a guarantor is crucial in the billing process, as their information is typically used to determine how and when payments will be collected. In healthcare settings, it is often the case that a patient may receive treatment and primary billing communications may occur not directly with the patient, but rather with the guarantor. This can be especially relevant when patients are minors or when there are insurance plans that require a different individual to handle the financial obligations associated with medical care. The other options do not accurately describe the role of a guarantor. While billing providers may work to ensure payments are received, they are not classified as guarantors. Systems and databases mentioned in other choices relate more to operational functions within healthcare management rather than the financial responsibility aspect that defines a guarantor.

3. What captures every coverage a patient has ever had?

- A. Patient Filing Order**
- B. Guarantor Account**
- C. Hospital Account Record**
- D. Enterprise Registration**

The correct choice is the Patient Filing Order, which is a comprehensive tracking mechanism that organizes a patient's different insurance coverages over time. Essentially, it serves as a detailed record of all insurance policies a patient has ever had, along with specifics about each coverage period. This is critical for billing and insurance claim purposes, ensuring that the healthcare provider can accurately bill the correct insurer based on the patient's coverage history. The Patient Filing Order is foundational in managing how claims are submitted to the insurance companies and prioritizing which insurance should be billed first based on the patient's current and previous coverage, along with contractual obligations. This data is essential for revenue cycle management, as it minimizes the risk of billing errors and enhances the overall efficiency of the billing process. In contrast, other options like the Guarantor Account, Hospital Account Record, and Enterprise Registration serve different roles. The Guarantor Account relates more to the individual responsible for paying the bill rather than the insurance coverage history. The Hospital Account Record typically contains details pertinent to a specific hospital visit or encounter, rather than a cumulative view of all patient coverages. Enterprise Registration deals with patient identity and basic information across the healthcare organization but does not encapsulate the history of insurance coverages.

4. What does the three-letter abbreviation known as an INI refer to in the context of a master file?

- A. Individual Numeric Identifier**
- B. Integrated Network Information**
- C. Internal Name Identifier**
- D. Instrumentation Number Index**

The three-letter abbreviation INI stands for Internal Name Identifier. In the context of a master file, this term is essential for distinguishing and identifying individual entries or components within the system. The Internal Name Identifier plays a critical role in how data elements are organized, classified, and referenced throughout the billing process. This identifier helps ensure that every piece of information is accurately linked to its corresponding patient or transaction record, allowing for streamlined operations and efficient data management within the Epic Resolute Professional Billing system. Understanding the significance of the INI can aid users in navigating the system more effectively and ensuring that all identifiers are correctly applied, ultimately promoting the integrity of data captured in the billing workflow.

5. What does the term 'DNB' refer to in an HB HAR context?

- A. Does Not Bill**
- B. Data Not Billed**
- C. Delivered Not Billed**
- D. Direction Not Billed**

In the context of Hospital Billing (HB) and Hospital Account Receivable (HAR), the term 'DNB' stands for "Does Not Bill." This indicates that a specific account or charge in the billing system is not currently set up to be billed. There can be various reasons for this status, such as the account being incomplete, awaiting additional information, or needing special adjustments before finalizing the billing process. Understanding the term 'Does Not Bill' is crucial for billing and revenue cycle professionals, as it helps in identifying which accounts require further action or oversight to ensure revenue is correctly captured and billed. This term helps the billing team manage accounts effectively and prevents delays in revenue flow that might occur if accounts are mistakenly left unbilled.

6. Which action is NOT typically required to make a coverage effective for past encounters?

- A. Undo billing for the HAR**
- B. Add the coverage in Registration**
- C. Notify the insurance provider**
- D. Document the reason for the lack of coverage**

The action that does not typically need to be taken to make coverage effective for past encounters is adding the coverage in Registration. When dealing with past encounters, it's crucial to ensure that any required adjustments related to billing or communication with the insurance provider are completed to facilitate the coverage. While it is necessary to undo the billing for the health access record (HAR) to allow for any necessary changes, and notifying the insurance provider is needed to clarify the coverage status, the actual addition of coverage in the Registration may not be necessary for past encounters already delivered. The focus is often on rectifying existing records and billing rather than modifying registration information for encounters that have already occurred. Thus, adding coverage at this stage does not align with the standard procedural requirements to address the past encounter issues effectively.

7. What do Master Files hold information about?

- A. Financial transactions
- B. Insurance coverage
- C. Particular types of data**
- D. Patient medical history

Master Files are designed to hold specific sets of information that relate to particular types of data within the Epic system. They serve as foundational components that provide the necessary data elements required for various processes, such as billing, claims processing, and reporting. These files include critical information and configurations that allow the system to operate effectively, such as provider details, patient demographics, and codes for billing. The focus is on maintaining data integrity and ensuring that the information is easily accessible for different functions within the system. The other options may sound relevant, but they represent more specific categories or forms of data rather than the broader, organized collections found in Master Files. For instance, while financial transactions and patient medical history are essential aspects of the healthcare industry, they fall under different categories and are managed differently compared to the generalized data held within Master Files.

8. Where can you identify the currently responsible payer from the storyboard?

- A. Visit coverages sections**
- B. Access the claims history
- C. Check the payment section
- D. Review the billing summary

Identifying the currently responsible payer from the storyboard is most accurately done by visiting the coverages section. This section explicitly outlines the insurance coverages associated with a patient's account, detailing which payers are currently responsible for bills and how coverage is managed. The coverages section typically provides vital information on each payer's start and end dates for coverage, along with any payer-specific requirements. This helps billing professionals understand at a glance which insurer is expected to reimburse for the healthcare services rendered. While the other sections like claims history, payment section, and billing summary contain valuable information regarding past claims, payments made, and overall billing status, they do not specifically highlight which payer is currently responsible for the account at that moment in time. Thus, the coverages section is the most direct and informative source for confirming the active payer responsible for the billing.

9. True or False: Refunds can be issued for payments collected at the front desk on the same day.

A. True

B. False

C. Only with managerial approval

D. Depends on system settings

The statement is true because refunds can indeed be issued for payments collected at the front desk on the same day. This process is often streamlined within the billing system to ensure that any overpayments or adjustments can be handled efficiently while the patient is still present. Front desk staff typically have the authority to process these refunds immediately, facilitating a smoother financial interaction and improving patient satisfaction. The ability to issue refunds on the same day helps maintain accurate financial records and ensures that any discrepancies are promptly addressed. This capability often reflects best practices in patient revenue management that aim to enhance the overall efficiency of the billing process. Other considerations, such as managerial approval or specific system settings, may vary based on organizational policies or technological constraints but are not universally applicable in all situations.

10. Which of the following is a common reason for claim denials?

A. Incorrect patient information

B. Uncommon medical procedures

C. Lack of electronic records

D. High patient volumes

The most common reason for claim denials is incorrect patient information. Accurate patient data is critical for processing claims effectively. When the information submitted to insurance companies does not match their records, it typically results in a denial. This can include discrepancies in the patient's name, date of birth, insurance policy number, or even the validity of the insurance coverage itself. Having accurate patient information not only helps in the approval process but also ensures that the provider is compensated for their services without unnecessary delays. Ensuring that all patient information is clean and correct before claims are submitted is therefore essential in minimizing the risk of denials due to inaccuracies. While uncommon medical procedures, lack of electronic records, and high patient volumes may also contribute to claim processing challenges, they are not as frequently cited as the root cause of denials compared to incorrect patient information.

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://epicresolutepbfundamentals.examzify.com>

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