

# Health Insurance Billing Practice Exam (Sample)

## Study Guide



**Everything you need from our exam experts!**

**This is a sample study guide. To access the full version with hundreds of questions,**

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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. Don't worry about getting everything right, 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, and take breaks to retain information better.**

## **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.**

## **7. Use Other Tools**

**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!**

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## **Questions**

- 1. Which document typically outlines the amount that a patient is responsible for after insurance processing?**
  - A. Invoice**
  - B. Statement of account**
  - C. Explanation of benefits**
  - D. Pre-authorization notice**
- 2. Select the correct entry for the name of a provider on the CMS-1500 claim.**
  - A. MARY SMITH MD**
  - B. MARY SMITH, MD**
  - C. DR. MARY SMITH**
  - D. SMITH, MARY, MD**
- 3. A hospital handling 290 inpatient cases assigned to DRG 169 with a relative weight of 1.106 has what total relative weight?**
  - A. 262.21**
  - B. 320.74**
  - C. 49,010.00**
  - D. 54,205.06**
- 4. What part of the claims process involves comparing the claim to payer edits and the patient's health plan benefits?**
  - A. Transmission**
  - B. Submission**
  - C. Adjudication**
  - D. Processing**
- 5. What is typically covered by a primary health insurance plan?**
  - A. Only hospital stays**
  - B. Preventive care services**
  - C. Ancillary services only**
  - D. Out-of-pocket expenses**



- 6. What is the process of assigning numeric and alphanumeric characters to diagnoses, procedures, and services called?**
- A. Coding**
  - B. Electronic data interchange**
  - C. Claims submission**
  - D. Billing**
- 7. What type of organization is usually owned by physicians or a hospital and provides practice management services to individual physician practices?**
- A. MSO**
  - B. IPO**
  - C. PHO**
  - D. GPWW**
- 8. Which organization is primarily responsible for developing standards for the accreditation of health care organizations?**
- A. The Joint Commission**
  - B. Health Care Financing Administration (HCFA)**
  - C. Institute for Healthcare Improvement (IHI)**
  - D. National Quality Forum (NQF)**
- 9. Which act requires hospitals to provide the Medicare Outpatient Observation Notice (MOON) to outpatients receiving observation services?**
- A. IMPACT Act**
  - B. HIPAA**
  - C. NOTICE Act**
  - D. MACRA**
- 10. Which is a professional association that was founded to elevate the standards of medical coding?**
- A. AMA**
  - B. AAPC**
  - C. DHHS**
  - D. CMS**

## **Answers**

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

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## **Explanations**

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**1. Which document typically outlines the amount that a patient is responsible for after insurance processing?**

- A. Invoice**
- B. Statement of account**
- C. Explanation of benefits**
- D. Pre-authorization notice**

The document that typically outlines the amount a patient is responsible for after insurance processing is the Explanation of Benefits (EOB). An EOB is issued by the insurance company and details how a claim was processed. It breaks down the costs associated with the medical service received, including the total charges, the amount covered by the insurance, any adjustments made, and the final amount that the patient needs to pay out-of-pocket. This transparency allows patients to understand their financial responsibility following insurance handling of their claim. In contrast, an invoice usually represents charges directly from a healthcare provider, but it may not reflect what the insurance has covered or any adjustments made. A statement of account may summarize multiple transactions but does not specifically provide insight into how insurance processed individual claims or what portion remains due after that processing. Finally, a pre-authorization notice is used to inform the provider or patient that a service is approved for coverage; however, it does not contain information about the patient's financial responsibility after the claim has been processed.

**2. Select the correct entry for the name of a provider on the CMS-1500 claim.**

- A. MARY SMITH MD**
- B. MARY SMITH, MD**
- C. DR. MARY SMITH**
- D. SMITH, MARY, MD**

The entry for the name of a provider on the CMS-1500 claim should follow specific formatting guidelines to ensure clarity and standardization. In this context, the correct choice, "MARY SMITH MD," adheres to the requirement of presenting the provider's name in a straightforward manner, without any punctuation or additional titles. Using "MARY SMITH MD" combines the provider's full name followed by their professional designation without the use of a comma or any other additional formatting elements, which aligns with the CMS-1500 guidelines for claim submission. It's essential for providers' names to be listed clearly to avoid any confusion during the claims processing stage. In contrast, other options that incorporate different formats, such as the addition of a comma or the title "DR." at the beginning, don't comply with these standards, making them less suitable for accurate claim submission. Hence, "MARY SMITH MD" is the preferred format for clarity and compliance with billing practices.

**3. A hospital handling 290 inpatient cases assigned to DRG 169 with a relative weight of 1.106 has what total relative weight?**

**A. 262.21**

**B. 320.74**

**C. 49,010.00**

**D. 54,205.06**

To find the total relative weight for the inpatient cases assigned to DRG 169, you multiply the number of cases by the relative weight of that DRG. In this scenario, you have 290 inpatient cases and a relative weight of 1.106 for DRG 169. The calculation would be: Total Relative Weight = Number of Cases  $\times$  Relative Weight Total Relative Weight =  $290 \times 1.106$  Performing this multiplication:  $290 \times 1.106 = 320.74$  The result of 320.74 represents the total relative weight for the hospital handling those inpatient cases. This total is essential as it can affect the reimbursement the hospital receives from insurers, impacting the financial management of hospital operations. The other provided choices offer values that do not align with the correct calculation of total relative weight based on the given data.

**4. What part of the claims process involves comparing the claim to payer edits and the patient's health plan benefits?**

**A. Transmission**

**B. Submission**

**C. Adjudication**

**D. Processing**

The adjudication phase of the claims process is critical because it involves a thorough review of the claim against the payer's established guidelines and the patient's specific health plan benefits. During this phase, the insurance company evaluates the information included in the claim—such as procedures performed, diagnosis codes, and other relevant details—to ensure that they align with the contractual agreements and policies of the health plan. This step is essential to determine the validity of the claim, including whether the services rendered are covered under the patient's plan, if they were medically necessary, and what portion of the costs will be paid by the insurer versus what the patient may owe. Adjudication often includes applying any edits set forth by the payer, which may flag discrepancies or necessitate further review for compliance. In contrast, the submission phase involves sending the claim to the payer, but does not involve this detailed evaluation. The transmission phase relates to the means of sending the claim, such as electronically or via paper, but it does not include any review or comparison aspects. Processing is a broader term that may encompass multiple operational steps, but it is not specifically focused on the detailed evaluation of the claim against payer standards and patient benefits, which is the crux of adjudication.

**5. What is typically covered by a primary health insurance plan?**

- A. Only hospital stays**
- B. Preventive care services**
- C. Ancillary services only**
- D. Out-of-pocket expenses**

A primary health insurance plan is designed to offer comprehensive coverage for various healthcare services, and one of the key aspects of such plans is the inclusion of preventive care services. Preventive care is essential in maintaining health and well-being, as it includes services like vaccinations, annual check-ups, screenings, and counseling aimed at preventing illnesses or detecting them early. Many primary health insurance plans cover these services at little to no cost to encourage individuals to seek regular medical care and maintain their health. The inclusion of preventive care helps reduce future healthcare costs by catching potential health issues before they become more serious. This focus on prevention is a foundational aspect of modern health insurance policies, aligning with public health goals to promote healthier populations. In contrast, the other options do not encompass the typical coverage of a primary health insurance plan as effectively. Hospital stays, while covered, are just one component of a much broader spectrum of services. Ancillary services, such as physical therapy or diagnostic imaging, may also be included but do not embody the foundational preventive care that's vital for the patient's overall health management. Out-of-pocket expenses represent costs that individuals must pay themselves and are not a form of coverage provided by the insurance plan. Thus, focusing on preventive care highlights the primary health insurance goal.

**6. What is the process of assigning numeric and alphanumeric characters to diagnoses, procedures, and services called?**

- A. Coding**
- B. Electronic data interchange**
- C. Claims submission**
- D. Billing**

The process of assigning numeric and alphanumeric characters to diagnoses, procedures, and services is known as coding. This is a critical function in health insurance billing as it provides a standardized method for representing medical conditions and services. Accurate coding ensures that healthcare providers are paid correctly and promptly for their services, and it supports statistical analysis and health care research. Coding involves the use of classification systems, such as the International Classification of Diseases (ICD) for diagnoses and the Current Procedural Terminology (CPT) for procedures. Each code corresponds to specific meanings, facilitating effective communication among health care providers, payers, and regulatory bodies. While electronic data interchange refers to the electronic transfer of data between entities, claims submission is the process of sending the completed claims to insurance companies for payment. Billing encompasses the overall process of charging patients or payers for services rendered, which includes coding but is broader in scope. Coding specifically focuses on the assignment of codes, making it the correct answer in this context.

**7. What type of organization is usually owned by physicians or a hospital and provides practice management services to individual physician practices?**

**A. MSO**

**B. IPO**

**C. PHO**

**D. GPWW**

The correct answer is the Management Services Organization (MSO). MSOs are designed to provide administrative and management services to individual physician practices. They can help streamline operations, reduce overhead costs, and allow physicians to focus more on patient care rather than administrative burdens. Typically owned by physicians or healthcare institutions like hospitals, MSOs are an effective way for providers to pool resources and share best practices, which enhances overall efficiency and profitability. In contrast, Integrated Physician Organizations (IPOs) generally focus on coordinating care among groups of physicians but may not exclusively provide practice management services. A Physician-Hospital Organization (PHO) involves a collaboration between hospitals and their affiliated physicians, primarily aimed at negotiating contracts with insurers and managing patient care, but it may also not focus solely on practice management. Lastly, GPWW, which may refer to a group practice with a varying purpose, is not a standard term in this context and would not be primarily focused on providing management services to physicians.

**8. Which organization is primarily responsible for developing standards for the accreditation of health care organizations?**

**A. The Joint Commission**

**B. Health Care Financing Administration (HCFA)**

**C. Institute for Healthcare Improvement (IHI)**

**D. National Quality Forum (NQF)**

The Joint Commission is primarily responsible for establishing standards for the accreditation of health care organizations. This organization plays a critical role in ensuring the quality and safety of health care by setting rigorous performance standards. These standards cover various aspects of patient care and organizational management, helping to enhance the quality and consistency of care delivered to patients. Accreditation by The Joint Commission is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. Health care organizations proactively seek this accreditation to demonstrate their dedication to improving patient care and safety while also maintaining compliance with regulatory requirements. In contrast, other organizations mentioned have different focuses. The Health Care Financing Administration (now known as the Centers for Medicare & Medicaid Services) primarily administers health care programs like Medicare and Medicaid but does not focus on accreditation standards. The Institute for Healthcare Improvement is dedicated to facilitating improvements in health care, primarily through education and operational guidance, rather than accreditation itself. The National Quality Forum focuses on endorsing standards for performance measurement rather than directly accrediting health care institutions. Hence, The Joint Commission stands out as the correct choice for developing accreditation standards.



**9. Which act requires hospitals to provide the Medicare Outpatient Observation Notice (MOON) to outpatients receiving observation services?**

- A. IMPACT Act**
- B. HIPAA**
- C. NOTICE Act**
- D. MACRA**

The Medicare Outpatient Observation Notice (MOON) is mandated by the NOTICE Act, which stands for Notice of Observation Treatment and Implication for Care Eligibility. This act was specifically designed to ensure that patients receiving outpatient observation services are informed about their status and the potential implications for their Medicare coverage. Under this law, hospitals must provide the MOON to patients when they are placed under observation status for more than 24 hours. This notice helps clarify the differences between outpatient observation and inpatient admission, which is crucial for beneficiaries to understand their coverage and potential financial responsibilities. The other acts listed, while significant in the context of healthcare regulations, do not specifically address the requirement for the MOON. The IMPACT Act focuses on improving healthcare quality and data sharing; HIPAA primarily addresses patient privacy and information security; and MACRA is centered around payment reforms in Medicare, particularly for physicians. None of these directly deal with the provision of the MOON to patients under observation services.

**10. Which is a professional association that was founded to elevate the standards of medical coding?**

- A. AMA**
- B. AAPC**
- C. DHHS**
- D. CMS**

The AAPC, or American Academy of Professional Coders, was specifically established to elevate the standards of medical coding and billing. Founded in 1988, AAPC focuses on providing education, certification, and training for professionals in the field of medical coding. Through its certifications, such as the Certified Professional Coder (CPC), AAPC sets quality standards in medical coding practices. The organization plays a crucial role in ensuring coders are well-prepared to accurately translate healthcare services into universally recognized codes, which is essential for proper reimbursement and compliance within the healthcare billing system. In contrast, the other organizations mentioned have different primary functions: the AMA (American Medical Association) focuses on promoting the art and science of medicine, DHHS (Department of Health and Human Services) oversees national health policies, and CMS (Centers for Medicare & Medicaid Services) administers the nation's major healthcare programs. While these organizations contribute significantly to healthcare, it is AAPC that is primarily dedicated to the education and advancement of medical coding specifically.

## 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](mailto:hello@examzify.com).**

**Or visit your dedicated course page for more study tools and resources:**

**<https://healthinsurancebilling.examzify.com>**

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