

HEALTH INSURANCE BILLING PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

**VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE**

<https://healthinsurancebilling.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. Which insurance is defined as reimbursement for income lost as a result of a temporary or permanent illness or injury?**
 - A. Disability
 - B. Liability
 - C. Indemnity
 - D. Fee-for-service
- 2. Who reviews health-related claims to determine whether charges are reasonable and medically necessary?**
 - A. Health care provider
 - B. Claims examiner
 - C. Medical assistant
 - D. Health insurance specialist
- 3. What is the term for a healthcare provider's request for reimbursement from an insurance company?**
 - A. Insurance claim
 - B. Billing statement
 - C. Cost analysis
 - D. Reimbursement form
- 4. What type of insurance system is designed for covering a wide range of healthcare expenses, typically with higher premiums?**
 - A. Health Maintenance Organization (HMO)
 - B. Major medical insurance
 - C. Short-term health insurance
 - D. Taxable health savings accounts
- 5. A condition existing at the time of an inpatient admission order is described as what?**
 - A. Revenue cycle auditing
 - B. Case management
 - C. Present on admission
 - D. Data analysis

- 6. What entity establishes a utilization management program and performs external reviews?**
- A. PPO
 - B. HMO
 - C. URO
 - D. POS
- 7. What is the coding system developed by the World Health Organization known as?**
- A. CPT
 - B. ICD
 - C. DSM
 - D. HCPCS level II
- 8. Resource utilization groups (RUGs) use which reimbursement methodology by skilled nursing facilities?**
- A. Managed care
 - B. Fee-for-service-based
 - C. Cost-based
 - D. Price-based
- 9. Which professionals are primarily responsible for billing patients directly for services rendered?**
- A. Receptionists
 - B. Claims examiners
 - C. Health insurance specialists
 - D. Insurance adjusters
- 10. Which document is primarily used by physicians to bill for services rendered?**
- A. CMS-1500
 - B. UB-04
 - C. Health care claim form
 - D. Superbill

Answers

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

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Explanations

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1. Which insurance is defined as reimbursement for income lost as a result of a temporary or permanent illness or injury?

- A. Disability**
- B. Liability
- C. Indemnity
- D. Fee-for-service

Disability insurance is specifically designed to provide income replacement for individuals who are unable to work due to a temporary or permanent illness or injury. This type of insurance helps to alleviate financial stress by offering a portion of the insured's income while they recover or adjust to a disability. The reimbursement structure is crucial in disability insurance; it typically pays a percentage of the insured's pre-disability income, allowing them to maintain their standard of living even if they are unable to engage in their usual employment due to health issues. This form of insurance is particularly important for those whose livelihoods depend on their ability to work, as it provides a safety net during times of health-related difficulties. It distinguishes itself by focusing not on medical costs, but rather on replacing lost income, thereby providing critical financial support when unexpected health challenges arise.

2. Who reviews health-related claims to determine whether charges are reasonable and medically necessary?

- A. Health care provider
- B. Claims examiner**
- C. Medical assistant
- D. Health insurance specialist

The claims examiner plays a crucial role in the health insurance process by reviewing health-related claims. Their primary responsibility is to evaluate whether the charges submitted for health services are reasonable and medically necessary according to the standards set by the insurance policy. Claims examiners scrutinize the details of the claims, including medical records, billing codes, and provider notes, to ensure that the services billed align with the diagnosis and treatment received by the patient. This assessment is essential for both the insurance company and the healthcare provider to ensure that resources are used appropriately and that patients receive necessary medical care without incurring unnecessary costs. In contrast, healthcare providers focus on delivering medical services to patients and may not be involved in the administrative review of claims. Medical assistants primarily assist with clerical tasks and patient care in healthcare settings, and while they may help in the billing process, they are not responsible for reviewing the claims themselves. Health insurance specialists may be involved in various aspects of insurance claims, such as coding or processing, but it is specifically the claims examiner who has the definitive role of determining the reasonableness and medical necessity of charges within the context of a claim.

3. What is the term for a healthcare provider's request for reimbursement from an insurance company?

- A. Insurance claim**
- B. Billing statement
- C. Cost analysis
- D. Reimbursement form

The term for a healthcare provider's request for reimbursement from an insurance company is an insurance claim. This claim is a formal request that healthcare providers submit to insurers for payment for the services rendered to patients. It includes important information such as the procedures performed, diagnosis codes, and patient details to facilitate the review and approval process by the insurance company. An insurance claim is the primary means by which providers seek to receive payment for their work and is essential for maintaining the financial health of healthcare practices. Upon receipt of the claim, the insurer evaluates it based on the patient's eligibility, coverage, and benefits outlined in their policy. Once approved, the insurer will reimburse the provider either partially or fully depending on the agreement in the patient's insurance plan. In contrast, a billing statement is a document sent to patients detailing the charges for services provided, while a cost analysis is more focused on evaluating the costs associated with services versus their returns. A reimbursement form is not the primary term used in healthcare billing but may refer to a specific document used in particular reimbursement scenarios.

4. What type of insurance system is designed for covering a wide range of healthcare expenses, typically with higher premiums?

- A. Health Maintenance Organization (HMO)
- B. Major medical insurance**
- C. Short-term health insurance
- D. Taxable health savings accounts

Major medical insurance is indeed designed to cover a wide range of healthcare expenses, making it a comprehensive option for individuals seeking robust health coverage. This type of insurance typically involves paying higher premiums, but in return, it provides extensive benefits. Purchasing major medical insurance means that policyholders can receive coverage for significant medical events, such as hospitalizations, surgeries, and catastrophic health issues. The intention behind this coverage is to protect individuals from high medical costs that could arise unexpectedly and potentially lead to financial hardship. In contrast, Health Maintenance Organizations (HMOs) usually offer lower premiums but come with restrictions regarding provider networks and require referrals for specialists, limiting the breadth of covered services. Short-term health insurance generally provides temporary coverage for gaps in insurance but does not cover pre-existing conditions or provide comprehensive care. Taxable health savings accounts are savings accounts intended to help individuals save for medical expenses but do not themselves provide insurance coverage.

5. A condition existing at the time of an inpatient admission order is described as what?

- A. Revenue cycle auditing
- B. Case management
- C. Present on admission**
- D. Data analysis

The term that describes a condition existing at the time of an inpatient admission order is "present on admission." This designation is used to clearly identify whether a diagnosis was present at the time of a patient's hospital admission. It is a crucial aspect of health care documentation and billing, as it impacts the classification of the patient's condition and the extent of care that may be covered by insurance. Understanding whether a condition is present on admission helps with the accurate coding of diagnoses, which affects reimbursement and hospital quality metrics. For example, if a patient develops a condition during their hospital stay, it may not be eligible for certain reimbursements, highlighting the importance of accurate documentation from the outset. The other concepts mentioned, such as revenue cycle auditing, case management, and data analysis, have their own specific roles in health care administration and billing but do not directly pertain to the definition of a condition that exists at the time of admission. Revenue cycle auditing focuses on the overall financial processes of health care services, case management deals with the coordination of care, and data analysis is about interpreting health data, none of which specifically address the timing of a patient's condition relative to their admission.

6. What entity establishes a utilization management program and performs external reviews?

- A. PPO
- B. HMO
- C. URO**
- D. POS

The correct choice is that a utilization review organization (URO) is responsible for establishing a utilization management program and performing external reviews. A URO focuses specifically on evaluating the necessity and efficiency of healthcare services, treatment plans, and procedures. By conducting these external reviews, the organization helps ensure that providers follow established guidelines and best practices, improving the quality and efficiency of care while managing costs. Utilization management involves assessing whether a patient's treatment is appropriate and necessary given their medical condition, which is a core function of a URO. Through these processes, UROs help to identify overutilization or underutilization of medical services, which can significantly impact both patient outcomes and healthcare expenditures. In this context, other entities like PPOs, HMOs, and POS plans may partake in utilization management to some degree, but they typically operate within their own networks and are focused more on providing healthcare services rather than independently reviewing and managing the necessity of those services on a broader scale. Therefore, while the other options have roles in healthcare delivery, they do not specifically function as independent organizations dedicated to utilization reviews in the same capacity as a URO does.

7. What is the coding system developed by the World Health Organization known as?

- A. CPT
- B. ICD**
- C. DSM
- D. HCPCS level II

The coding system developed by the World Health Organization is known as ICD, which stands for the International Classification of Diseases. This system is designed to systematically categorize diseases, health-related issues, and other factors influencing health. The ICD codes are used globally for various purposes, including health management, population health assessment, and health care billing. ICD codes help ensure a standardized method for classifying diseases, facilitating the collection, comparison, and analysis of health information across different settings and populations. This coding system evolves over time to incorporate new knowledge and advancements in medicine, with the most recent version being ICD-11. While other codes like CPT (Current Procedural Terminology) are used primarily in the United States for reporting medical procedures and services, and DSM (Diagnostic and Statistical Manual of Mental Disorders) focuses on mental health diagnoses, these are not developed by the World Health Organization. HCPCS Level II codes are utilized for billing specific non-physician services and are maintained by the Centers for Medicare & Medicaid Services. Thus, the ICD is the correct coding system associated with the World Health Organization.

8. Resource utilization groups (RUGs) use which reimbursement methodology by skilled nursing facilities?

- A. Managed care
- B. Fee-for-service-based
- C. Cost-based**
- D. Price-based

Resource Utilization Groups (RUGs) employ a cost-based reimbursement methodology for skilled nursing facilities. This system categorizes patients based on their care needs and the resources required to provide that care, effectively aligning reimbursement with the anticipated costs of care. Using RUGs, skilled nursing facilities receive payments determined by the level of care patients require, which is assessed through their clinical profiles and service needs. This approach allows for a more accurate reflection of the resources utilized in patient care, ensuring that facilities are reimbursed according to the complexity and intensity of services provided. The cost-based methodology is designed to cover the expenses incurred by the facilities, ensuring they can maintain quality care. Each RUG classification corresponds to a specific payment rate, allowing skilled nursing facilities to manage their operational costs effectively while delivering the necessary level of care for patients.

9. Which professionals are primarily responsible for billing patients directly for services rendered?

- A. Receptionists
- B. Claims examiners
- C. Health insurance specialists**
- D. Insurance adjusters

Health insurance specialists are primarily responsible for billing patients directly for services rendered. They have the specific training and expertise to handle various aspects of billing and reimbursement. This includes preparing and submitting claims to insurance companies, managing patient accounts, and ensuring that services rendered are accurately documented and billed. These specialists understand the intricacies of health insurance policies and are skilled in coding procedures and diagnoses, which are vital for the billing process. In contrast, receptionists mainly manage front office tasks, such as scheduling appointments and greeting patients, rather than focusing directly on billing and collections. Claims examiners review and process claims submitted by healthcare providers, ensuring compliance with insurance regulations, but they typically do not bill patients directly. Insurance adjusters work for insurance companies to evaluate and settle claims, rather than interacting directly with patients regarding billing. Thus, the role of health insurance specialists is crucial in the direct billing process, making them the correct choice in this scenario.

10. Which document is primarily used by physicians to bill for services rendered?

- A. CMS-1500**
- B. UB-04
- C. Health care claim form
- D. Superbill

The CMS-1500 form is primarily used by physicians and other health care providers to submit claims for reimbursement for services rendered to patients. This form is standardized and widely accepted by various insurance carriers for processing professional medical claims. The CMS-1500 captures essential information such as the patient's demographic details, insurance information, diagnosis codes, and procedure codes, which are critical for accurately billing and receiving payment from insurance companies. While the UB-04 form is used mainly by hospitals and other institutional providers to bill for facility services, and the healthcare claim form might refer to various types of claims processing forms, the term "superbill" typically refers to an internal document used by physicians that lists services rendered but isn't submitted directly to insurers. Each of these alternatives has specific contexts and uses, but the CMS-1500 is the primary form for individual physicians to bill for their services.

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://healthinsurancebilling.examzify.com>

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

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