

Health Insurance Claim (CMS-1500) Form 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 block would you reference in order to point to the diagnosis code in Block 21?**
 - A. Block 24E**
 - B. Block 24D**
 - C. Block 20**
 - D. Block 23**

- 2. What is the main purpose of the CMS-1500 form?**
 - A. To submit insurance claims for reimbursement**
 - B. To provide medical history of the patient**
 - C. To authorize medical treatments**
 - D. To document appointment schedules**

- 3. What should be written in Block 7 if the insured is the same as the patient?**
 - A. NOT APPLICABLE**
 - B. SAME**
 - C. DIFFERENT**
 - D. PRIMARY**

- 4. What is the significance of including the NPI in Block 32A?**
 - A. It acts as a unique identifier for services**
 - B. It ensures compliance with federal regulations**
 - C. It facilitates faster claim processing**
 - D. It provides a record for insurance audits**

- 5. What should be entered in Block 24D of the CMS-1500 form?**
 - A. Diagnosis codes**
 - B. Procedures, services, and supplies**
 - C. Prior authorization number**
 - D. Provider's name**

6. What is the purpose of box 9 on the CMS-1500 form?

- A. To document the patient's medical diagnosis**
- B. To provide information on services rendered**
- C. To disclose other insurance coverage for coordination of benefits**
- D. To indicate the insured's group policy number**

7. What is typically required from the patient before submitting a CMS-1500 claim?

- A. A consent form**
- B. The patient's medical history**
- C. The patient's insurance policy number**
- D. The diagnosis code**

8. What information is documented in box 27 of the CMS-1500 form?

- A. Patient's date of birth**
- B. Provider's acceptance of claim assignment**
- C. Charges by procedure**
- D. Total billed amount by the provider**

9. What is a critical reason for maintaining patient confidentiality when filling out the CMS-1500 form?

- A. To improve the processing speed of claims.**
- B. To comply with HIPAA regulations.**
- C. To enhance patient communication with providers.**
- D. To allow insurance companies to market to patients.**

10. What is the primary purpose of the CMS-1500 form?

- A. To apply for government grants**
- B. To submit health insurance claims for reimbursement**
- C. To record patient medical history**
- D. To document physician credentials**

Answers

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

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Explanations

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1. Which block would you reference in order to point to the diagnosis code in Block 21?

- A. Block 24E**
- B. Block 24D**
- C. Block 20**
- D. Block 23**

To accurately reference the diagnosis code in Block 21 of the CMS-1500 form, you would look at Block 24E. This block is designated for the corresponding diagnosis code(s) that relate to the procedure or service reported in Block 24D. Each procedure or service requires a reference to a diagnosis code in Block 21, ensuring that the payers understand the medical necessity of the services rendered. The clarity between these blocks aids in proper claims processing and helps prevent delays or denials. Block 24D explains the procedure performed, while Block 24E connects it to the appropriate diagnosis from Block 21, demonstrating the link between the medical condition and the provided service.

2. What is the main purpose of the CMS-1500 form?

- A. To submit insurance claims for reimbursement**
- B. To provide medical history of the patient**
- C. To authorize medical treatments**
- D. To document appointment schedules**

The primary purpose of the CMS-1500 form is to submit insurance claims for reimbursement. This standardized form is utilized by healthcare providers and practitioners to report services, procedures, and diagnoses associated with patient care to insurance companies. By using the CMS-1500 form, providers ensure that the necessary information is communicated effectively and consistently, facilitating the claims process for payment. The other options, while important in different contexts, do not align with the main function of the CMS-1500 form. Providing medical history, authorizing treatments, and documenting appointment schedules involve different processes and paperwork outside the scope of insurance claim submission. The CMS-1500 is specifically designed for the purpose of seeking reimbursement for healthcare services rendered to patients, making it a vital tool in the healthcare billing process.

3. What should be written in Block 7 if the insured is the same as the patient?

- A. NOT APPLICABLE**
- B. SAME**
- C. DIFFERENT**
- D. PRIMARY**

When the insured is the same as the patient, it is appropriate to write "SAME" in Block 7 of the CMS-1500 form. This indicates to the payer that the individual receiving the services is also the individual whose insurance coverage is being billed. It helps streamline processing and clarifies that the patient and the insured party do not differ, which aids in reducing potential claims processing errors. The other options do not accurately convey the relationship between the insured and the patient in a way that is recognized or required in the context of the CMS-1500 form. For instance, "NOT APPLICABLE" does not provide any relevant information about the status of the insured. "DIFFERENT" would be misleading, suggesting that the patient and insured are not the same, which is contrary to the premise of the question. "PRIMARY" would imply a particular type of insurance coverage but does not address the direct relationship of the patient to the insured. Thus, writing "SAME" provides the necessary clarity that aligns with the requirements of the claims process.

4. What is the significance of including the NPI in Block 32A?

- A. It acts as a unique identifier for services**
- B. It ensures compliance with federal regulations**
- C. It facilitates faster claim processing**
- D. It provides a record for insurance audits**

Including the NPI (National Provider Identifier) in Block 32A is significant because it serves as a unique identifier for healthcare providers in the United States. This unique identification is designed to streamline and standardize the identification of healthcare providers across various settings and systems. By having the NPI present in Block 32A, it helps facilitate faster claim processing. The NPI is crucial for insurance companies to confirm the identity of the provider submitting the claim, which leads to more efficient validation of claims and reduces the likelihood of errors or delays. The quicker the claims can be verified and processed, the faster providers receive payment for services rendered, which is vital for the cash flow of a medical practice. While compliance with federal regulations and creating records for insurance audits are important aspects of using NPIs in general, the primary role of the NPI in this particular block is its function in expediting the claims process.

5. What should be entered in Block 24D of the CMS-1500 form?

- A. Diagnosis codes**
- B. Procedures, services, and supplies**
- C. Prior authorization number**
- D. Provider's name**

Block 24D of the CMS-1500 form is specifically designated for entering the procedures, services, and supplies that were provided to the patient. This block is essential for the insurance company to understand exactly what services were rendered and allows for accurate processing of the claim. When filling out this block, healthcare providers enter the appropriate CPT (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Coding System) codes that correspond to the services they performed. This information is critical as it determines not only the reimbursement the provider will receive but also helps the insurance payer assess the medical necessity of the services. In contrast, diagnosis codes are recorded in Block 21, the prior authorization number belongs in Block 23, and the provider's name is typically found in Block 33. Each block on the CMS-1500 form has a distinct purpose, making accurate completion essential for claims processing and payment.

6. What is the purpose of box 9 on the CMS-1500 form?

- A. To document the patient's medical diagnosis**
- B. To provide information on services rendered**
- C. To disclose other insurance coverage for coordination of benefits**
- D. To indicate the insured's group policy number**

Box 9 on the CMS-1500 form is designated for disclosing other insurance coverage for coordination of benefits. This section is crucial for health insurance claims because it allows the provider to indicate whether the patient has additional insurance that may cover all or part of the services being billed. This information is key for the insurance companies involved to determine how payments will be coordinated between different insurance plans, ensuring that the patient does not receive duplicate coverage for the same services and that claims are processed efficiently. Understanding the purpose of this box helps providers avoid potential billing issues, as it influences how claims are handled and can prevent delays in payment. It also plays an important role in ensuring that all insurance information is accurately reported, which is vital for maintaining compliance and proper reimbursement practices in the healthcare industry.

7. What is typically required from the patient before submitting a CMS-1500 claim?

- A. A consent form**
- B. The patient's medical history**
- C. The patient's insurance policy number**
- D. The diagnosis code**

Submitting a CMS-1500 claim typically requires a consent form from the patient. This consent form is crucial as it demonstrates that the patient has authorized the healthcare provider to release their medical information to the insurance company for processing the claim. The consent ensures compliance with privacy regulations and informs the patient about the use of their health information. While a patient's medical history, insurance policy number, and diagnosis code are important pieces of information that contribute to the claim process, the requirement for a consent form stands out as it legally permits the handling of sensitive health information. The consent protects both the patient's rights and the healthcare provider's ability to receive reimbursement for services rendered.

8. What information is documented in box 27 of the CMS-1500 form?

- A. Patient's date of birth**
- B. Provider's acceptance of claim assignment**
- C. Charges by procedure**
- D. Total billed amount by the provider**

Box 27 of the CMS-1500 form is designated for the provider's acceptance of claim assignment. This box is used to indicate whether the provider agrees to accept the payment amount determined by the insurance company for the services rendered. By marking this box, the healthcare provider is effectively stating that they will accept the insurance payment as payment in full for the services provided to the patient. This is an important aspect of the claims process, as it impacts both how the claim is processed by the insurance company and the financial relationship between the provider and the patient. The information in this box is crucial for the insurer to understand whether they are dealing with a contractual obligation where the provider agrees to certain terms for payment. This helps streamline the claims process and ensures that patients are not billed for amounts beyond what their insurance covers, provided the assignment is accepted.

9. What is a critical reason for maintaining patient confidentiality when filling out the CMS-1500 form?

- A. To improve the processing speed of claims.**
- B. To comply with HIPAA regulations.**
- C. To enhance patient communication with providers.**
- D. To allow insurance companies to market to patients.**

Maintaining patient confidentiality when filling out the CMS-1500 form is critically important due to the requirement to comply with HIPAA (Health Insurance Portability and Accountability Act) regulations. HIPAA establishes a set of national standards for the protection of individuals' medical records and other personal health information. It mandates that healthcare providers, health plans, and other entities that handle health information take necessary steps to protect the privacy and security of patient data. By adhering to HIPAA regulations, healthcare providers ensure that sensitive patient information is not disclosed without consent, thus safeguarding patients' rights to privacy. This compliance not only protects patients but also helps healthcare organizations avoid legal repercussions and potential fines. In this context, upholding patient confidentiality is not merely a best practice; it is a legal obligation that fosters trust between the patient and healthcare provider. The other options, while potentially relevant in different contexts, do not directly address the fundamental legal and ethical responsibilities regarding patient confidentiality set forth by HIPAA.

10. What is the primary purpose of the CMS-1500 form?

- A. To apply for government grants**
- B. To submit health insurance claims for reimbursement**
- C. To record patient medical history**
- D. To document physician credentials**

The primary purpose of the CMS-1500 form is to submit health insurance claims for reimbursement. This form is widely used by healthcare providers to bill insurance companies for services rendered to patients. When a provider diagnoses a patient, they use the CMS-1500 to detail the services provided, including the nature of the treatment, the diagnosis codes, and other relevant information required by insurance payers to process the claim effectively. Completing the CMS-1500 accurately is crucial for ensuring that the healthcare provider is reimbursed for the services they have provided and for maintaining the financial health of their practice. The information included on the CMS-1500 helps insurance companies to determine eligibility for coverage and the appropriate payment amounts, ultimately facilitating the claims process for both providers and payers.

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://cms1500form.examzify.com>

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

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