

HEALTH INSURANCE CLAIM (CMS-1500) FORM PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED 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. 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. What should be verified before resubmitting a denied claim using the CMS-1500?**
 - A. The patient's previous treatment dates
 - B. The reason for the denial
 - C. The insurance company's office hours
 - D. The severity of the medical condition
- 2. What goes in box 25 of the CMS-1500 form?**
 - A. Diagnosis codes
 - B. Provider billing number
 - C. Federal Tax ID or Social Security number
 - D. Patient's insurance policy number
- 3. What details must be entered in box 29 of the CMS-1500 form?**
 - A. Provider's signature
 - B. Additional amounts due for the claim
 - C. The patient's contact information
 - D. Modifiers for billing
- 4. What information is required in Block 5 of the CMS-1500 form?**
 - A. Insured's relationship to the patient
 - B. Patient's mailing address and telephone number
 - C. Patient's insurance policy number
 - D. Detail of medical conditions
- 5. In which box is the National Provider Identifier (NPI) number recorded?**
 - A. Box 21
 - B. Box 24F
 - C. Box 25
 - D. Box 33

- 6. What format should the patient's birth date be recorded on the CMS-1500 form?**
- A. MM/DD/YY
 - B. MM-DD-CCYY
 - C. MM/DD/CCYY
 - D. CCYY/MM/DD
- 7. What is the purpose of the Coordination of Benefits Agreement in Block 9 D?**
- A. To ensure eligibility for benefits
 - B. To identify the order of payment between multiple insurers
 - C. To provide contact information for claims processing
 - D. To verify coverage limits
- 8. What is an important aspect of the CMS-1500 form regarding patient information?**
- A. It must be shared with all medical professionals.
 - B. It protects sensitive personal health information.
 - C. It is only required for emergencies.
 - D. It must be printed in multiple languages.
- 9. What is the significance of the "Assignment of Benefits" on the CMS-1500?**
- A. It is a legal requirement for all providers
 - B. It permits insurance payments to go directly to the provider
 - C. It monitors patient compliance with treatment
 - D. It indicates the patient's financial responsibility
- 10. Which detail is crucial for ensuring that a claim is processed correctly when using the CMS-1500?**
- A. Patient's favorite doctor
 - B. History of previous claims
 - C. Accurate billing codes
 - D. Social security number of the patient

Answers

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

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Explanations

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1. What should be verified before resubmitting a denied claim using the CMS-1500?

- A. The patient's previous treatment dates
- B. The reason for the denial**
- C. The insurance company's office hours
- D. The severity of the medical condition

Verifying the reason for the denial is crucial before resubmitting a claim using the CMS-1500 form. Understanding why the initial claim was denied allows the healthcare provider or biller to address the specific issue, whether it was due to lack of information, incorrect coding, or coverage issues. By identifying the denial reason, the resubmission can be accurately adjusted to provide the necessary documentation or correct any errors that led to the previous denial. This step increases the likelihood of an approved claim upon resubmission, ultimately improving the cash flow for the practice. In contrast, although knowing the patient's previous treatment dates, the insurance company's office hours, or the severity of the medical condition might be useful in specific contexts, they do not directly address the core issue of why the claim was denied. Hence, those factors do not provide the necessary insights needed for a successful resubmission.

2. What goes in box 25 of the CMS-1500 form?

- A. Diagnosis codes
- B. Provider billing number
- C. Federal Tax ID or Social Security number**
- D. Patient's insurance policy number

Box 25 of the CMS-1500 form is designated for the provider's billing information, specifically the Federal Tax Identification Number (TIN) or the Social Security Number (SSN) if an individual provider is billing for services. This information is essential as it helps the insurance payer identify the provider for reimbursement purposes and ensures that the payments are accurately directed to the correct entity or individual. Providing the correct TIN or SSN is important for compliance with tax regulations and for avoiding payment delays. In some cases, a TIN may be preferred over an SSN for privacy and security reasons, especially when billing on behalf of a business entity. Including this information in box 25 facilitates the processing of claims and helps to verify that the claim is being submitted by an authorized provider, thereby safeguarding against potential fraudulent activities. Thus, the correct choice accurately reflects the purpose and requirements of that section of the CMS-1500 form.

3. What details must be entered in box 29 of the CMS-1500 form?

- A. Provider's signature
- B. Additional amounts due for the claim**
- C. The patient's contact information
- D. Modifiers for billing

Box 29 of the CMS-1500 form is specifically designated for "Amount Paid." This box is used by the provider to indicate any payment that has already been received for the medical services billed. This could encompass payments received from the patient or any other payer. By entering the additional amounts due for the claim in this box, it informs the insurance carrier of previous payments so they can calculate the remaining balance owed to the provider for that particular claim. The other options do not belong in box 29 based on the form's guidelines. The provider's signature is typically found in box 31 and is not required in box 29. Patient contact information is not relevant to this section and is usually found in other designated areas of the form. Modifiers for billing, which help clarify the procedure codes or services provided, are generally indicated in the itemization boxes for procedures, rather than in box 29.

4. What information is required in Block 5 of the CMS-1500 form?

- A. Insured's relationship to the patient
- B. Patient's mailing address and telephone number**
- C. Patient's insurance policy number
- D. Detail of medical conditions

Block 5 of the CMS-1500 form is specifically designed to capture the relationship of the insured individual to the patient. In the context of health insurance claims, it is crucial to identify whether the patient is the policyholder, spouse, dependent, or has another connection to the policy to ensure accurate billing and processing of the claim. This relationship plays a significant role in determining eligibility for coverage and the correct party responsible for payment. In contrast, the other options pertain to different details that are necessary for a complete claim but belong to different blocks on the form. For instance, the patient's mailing address and telephone number is found in Block 3, while the patient's insurance policy number is typically recorded in Block 1a. Medical condition details are documented in the designated sections for diagnosis codes. Therefore, understanding the correct content for each block is essential for competent completion of the CMS-1500 form.

5. In which box is the National Provider Identifier (NPI) number recorded?

- A. Box 21
- B. Box 24F
- C. Box 25
- D. Box 33**

The National Provider Identifier (NPI) number is recorded in Box 33 of the CMS-1500 form. This box is designated for the "Provider's NPI" as part of the claim submission process. It is essential because the NPI serves as a unique identifier for healthcare providers, enabling smooth processing and ensuring that claims are linked to the correct providers for reimbursement purposes. The importance of accurately entering the NPI in Box 33 cannot be overstated, as it is a critical component for identifying the provider rendering the services documented in the claim. This helps to streamline the administrative aspects of healthcare and allows for easier tracking and management of reimbursement from insurance companies. The other boxes mentioned pertain to different types of information. For instance, Box 21 is used for diagnoses or conditions, Box 24F is for the rendering provider's NPI when applicable, and Box 25 is for Federal Tax Identification Number or Social Security Number. Understanding where to place specific identifiers like the NPI is crucial for both compliance and efficient claims processing.

6. What format should the patient's birth date be recorded on the CMS-1500 form?

- A. MM/DD/YY
- B. MM-DD-CCYY
- C. MM/DD/CCYY**
- D. CCYY/MM/DD

The correct format for recording the patient's birth date on the CMS-1500 form is MM/DD/CCYY. This format is specific and standardized for consistency and clarity in medical billing and claims processing. Using the MM/DD/CCYY format ensures that the month is listed first, followed by the day and then the four-digit year. This is particularly important in healthcare settings to avoid any confusion that might arise from differing date formats used in various regions or systems. By utilizing this specific format, healthcare providers can guarantee that the information submitted to insurance companies is clear and unambiguous, which helps in expediting claims processing and reduces the likelihood of errors that might delay reimbursement. In contrast, the other formats present different arrangements of the date or use elements that do not align with CMS-1500 specifications, potentially leading to confusion or claim denials.

7. What is the purpose of the Coordination of Benefits Agreement in Block 9 D?

- A. To ensure eligibility for benefits
- B. To identify the order of payment between multiple insurers**
- C. To provide contact information for claims processing
- D. To verify coverage limits

The purpose of the Coordination of Benefits Agreement in Block 9 D is to identify the order of payment between multiple insurers. This is essential when a patient has coverage from more than one health insurance plan. Determining the primary and secondary payers helps avoid duplicate payments and ensures that claims are processed efficiently and accurately. When this block is filled out correctly, it indicates which insurer is primarily responsible for paying the claim, and which one will provide supplemental coverage. This process is important for compliance with insurance guidelines and helps streamline the claims process. Proper coordination of benefits allows healthcare providers to bill the correct insurer first, thus reducing delays in payment and ensuring that patients are not billed for amounts that should be covered by their insurance.

8. What is an important aspect of the CMS-1500 form regarding patient information?

- A. It must be shared with all medical professionals.
- B. It protects sensitive personal health information.**
- C. It is only required for emergencies.
- D. It must be printed in multiple languages.

Choosing the option that states the CMS-1500 form protects sensitive personal health information highlights the critical role of HIPAA (Health Insurance Portability and Accountability Act) in healthcare. The CMS-1500 form, which is widely used for billing and claims in the healthcare system, contains detailed patient information, including personal identifiers, diagnosis codes, and treatment details. Protection of this sensitive information is paramount to maintain patient confidentiality and integrity. When handling this form, healthcare providers are obligated to ensure that the data is shared appropriately and safeguarded against unauthorized access. This aligns with regulatory requirements designed to protect patient privacy. In contrast, the other options do not accurately represent the primary purpose and requirements of the CMS-1500 form. Sharing the form with all medical professionals (the first option) contravenes the principles of privacy and patient confidentiality set forth by HIPAA. The notion that the form is only required in emergencies (the third option) ignores its routine use for non-emergency situations and various healthcare services. Lastly, while there may be considerations for language access in healthcare, requiring the form to be printed in multiple languages (the fourth option) is not a standard requirement tied to the CMS-1500's function.

9. What is the significance of the "Assignment of Benefits" on the CMS-1500?

- A. It is a legal requirement for all providers
- B. It permits insurance payments to go directly to the provider**
- C. It monitors patient compliance with treatment
- D. It indicates the patient's financial responsibility

The "Assignment of Benefits" section on the CMS-1500 form holds considerable importance as it allows insurance payments to be directed to the healthcare provider rather than the insured patient. This is crucial for providers since it ensures they receive payment directly from the insurance company, which in turn helps streamline the billing process and reduces the potential for delayed payments. By having the assignment, providers can rely on quicker reimbursement and are less burdened by the administrative complications of billing patients directly. This also serves to enhance cash flow for medical practices, allowing them to focus more on patient care than on collection efforts. In contrast, the other options do not accurately reflect the purpose or significance of the "Assignment of Benefits." While compliance monitoring and financial responsibility are important aspects of healthcare management, they are not directly related to the central function of this section on the claim form. Furthermore, it is not a legal requirement for all providers but rather an option that must be agreed upon by the patient, making it essential to understand its purpose in ensuring efficient claim processing.

10. Which detail is crucial for ensuring that a claim is processed correctly when using the CMS-1500?

- A. Patient's favorite doctor
- B. History of previous claims
- C. Accurate billing codes**
- D. Social security number of the patient

Accurate billing codes are crucial for ensuring that a claim is processed correctly when using the CMS-1500 form. The billing codes, derived from the Current Procedural Terminology (CPT) and the International Classification of Diseases (ICD) systems, specify the services provided, diagnoses made, and any procedures performed during a patient's visit. These codes are essential for the insurance company to understand what care was rendered and to determine the appropriate reimbursement. Without accurate coding, claims can be denied or delayed, as insurance companies rely on these codes to assess coverage, medical necessity, and the appropriateness of the billed services. This level of detail not only ensures that healthcare providers receive timely payment but also helps maintain compliance with insurance regulations and standards. The other options, while they may contain relevant information in different contexts, do not directly impact the claim's processing as fundamentally as accurate billing codes do. For example, a patient's favorite doctor, the history of previous claims, or a patient's social security number may not directly influence how efficiently a claim is evaluated by an insurance provider.

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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