

# Medical Billing and Reimbursement 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

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- 1. What is required in Block 24J of the CMS-1500 form?**
  - A. The provider's license number.**
  - B. The tax ID number.**
  - C. The NPI number of the rendering provider.**
  - D. The facility's address.**
  
- 2. Which type of referral is given when time is critical?**
  - A. Regular referral.**
  - B. Urgent referral.**
  - C. STAT referral.**
  - D. No referral required.**
  
- 3. What is the purpose of Block 25 on the CMS-1500 form?**
  - A. To record the Federal Tax ID Number.**
  - B. The patient's insurance policy number.**
  - C. The diagnosis code.**
  - D. The provider's NPI.**
  
- 4. Who is ultimately responsible for paying the medical bill?**
  - A. The guarantor is the person ultimately responsible for the bill.**
  - B. The patient is always the payer of the bill.**
  - C. The insurer pays everything automatically.**
  - D. The provider writes off the balance without guarantor involvement.**
  
- 5. What is the impact of accurate coding in medical billing?**
  - A. Accurate coding ensures proper reimbursement and reduces the likelihood of claim denials.**
  - B. It guarantees fastest processing.**
  - C. It eliminates patient responsibility.**
  - D. It reduces data entry time.**

- 6. What describes the role of the medical coder in relation to providers?**
- A. To supervise the coding staff's day-to-day tasks.**
  - B. To perform patient intake interviews.**
  - C. To discuss the benefits of using updated encounter forms with providers.**
  - D. To approve insurance contracts.**
- 7. Which items belong on the patient information form?**
- A. The patient's social media accounts.**
  - B. All pertinent insurance information and a medical release of information form.**
  - C. The clinic's procurement records.**
  - D. The physician's favorite color.**
- 8. What is the standard form accepted by all health insurance companies?**
- A. CMS-1500 form**
  - B. UB-04 form**
  - C. CPT claim form**
  - D. HCFA-1500**
- 9. Which component is typically required to process a claim?**
- A. The patient's clinical notes.**
  - B. The physician's personal preferences.**
  - C. Details of services provided and associated costs.**
  - D. Information on the patient, the insurer, and the services and charges.**
- 10. Which action must be taken to ensure ICD-10-CM diagnoses are captured on the CMS-1500 form?**
- A. Ensure ICD-10-CM diagnoses are entered in Block 21.**
  - B. Enter only the primary diagnosis in Block 18.**
  - C. Leave Block 21 blank if the patient has a diagnosis.**
  - D. Enter the patient's SSN in Block 21.**

## Answers

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

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## **Explanations**

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**1. What is required in Block 24J of the CMS-1500 form?**

- A. The provider's license number.**
- B. The tax ID number.**
- C. The NPI number of the rendering provider.**
- D. The facility's address.**

Block 24J is where you enter the NPI of the rendering provider—the clinician who performed the service. The National Provider Identifier is a unique 10-digit number assigned under HIPAA to identify individual practitioners in electronic health transactions. Placing the rendering provider's NPI in this field ensures the payer can correctly link the service to the right provider, which supports accurate adjudication and auditing. In clinical claims, NPIs are the standard identifier used by payers, replacing older identifiers like license numbers for this purpose. The license number isn't used here because it's a credentialing detail, not the billing identifier; the tax ID belongs to the billing entity and appears in other claim fields; the facility address is captured elsewhere as the service location, not in this field.

**2. Which type of referral is given when time is critical?**

- A. Regular referral.**
- B. Urgent referral.**
- C. STAT referral.**
- D. No referral required.**

In time-critical situations, the level of urgency signals how fast help is needed. A STAT referral is the highest-priority request and is acted on immediately, often within minutes to an hour, to get rapid specialist input or urgent intervention. This is why it's the best choice when time is critical. Regular referrals follow routine scheduling, and urgent referrals are faster than regular but not immediate. No referral required means no escalation is needed.

**3. What is the purpose of Block 25 on the CMS-1500 form?**

- A. To record the Federal Tax ID Number.**
- B. The patient's insurance policy number.**
- C. The diagnosis code.**
- D. The provider's NPI.**

Block 25 collects the Federal Tax Identification Number of the billing provider or organization submitting the claim. This identifier is used by payers for tax reporting and to link the claim to the correct legal entity, helping ensure payments are issued to the right business and reported properly to the IRS. It's a tax-identity detail, not the patient's policy number, nor the diagnosis code, and it's separate from the provider's NPI, which is stored in a different field.

#### 4. Who is ultimately responsible for paying the medical bill?

- A. The guarantor is the person ultimately responsible for the bill.**
- B. The patient is always the payer of the bill.**
- C. The insurer pays everything automatically.**
- D. The provider writes off the balance without guarantor involvement.**

The guarantor is the person who signs the financial responsibility and is legally obligated to pay what remains of the bill. Even with insurance, the guarantor bears responsibility for any balance after the insurer pays according to plan benefits, including deductibles, coinsurance, and any services not covered. Insurance payments aren't guaranteed to cover the full amount because coverage varies and claims are adjudicated. The provider can't simply write off the balance without involvement, except in rare cases like approved charity adjustments or negotiated discounts. So, the guarantor is the one ultimately responsible for paying the medical bill.

#### 5. What is the impact of accurate coding in medical billing?

- A. Accurate coding ensures proper reimbursement and reduces the likelihood of claim denials.**
- B. It guarantees fastest processing.**
- C. It eliminates patient responsibility.**
- D. It reduces data entry time.**

Accurate coding directly impacts reimbursement and the likelihood of claims being denied due to coding errors. When clinical documentation is translated into the correct codes—CPT/HCPCS for procedures and ICD-10-CM for diagnoses—it shows the true services provided and medical necessity. Payers rely on these codes to determine payment, so precision reduces errors, rework, and denials, which improves cash flow and compliance with coding rules. However, accurate coding alone does not guarantee the fastest processing; claim timing depends on many steps in the payer's workflow. It also does not eliminate patient responsibility, which is determined by the patient's insurance plan and benefits. And while accurate coding helps prevent errors, it doesn't necessarily reduce data entry time, since the coding process requires careful review and can take additional time, even though it minimizes edits later.

**6. What describes the role of the medical coder in relation to providers?**

- A. To supervise the coding staff's day-to-day tasks.**
- B. To perform patient intake interviews.**
- C. To discuss the benefits of using updated encounter forms with providers.**
- D. To approve insurance contracts.**

Understanding how coders interact with clinicians is key: a medical coder translates the provider's documented visit into standardized codes for billing, so accurate coding hinges on having documentation and tools that prompt complete data capture.

Discussing the benefits of using updated encounter forms with providers is the best choice because these forms guide what needs to be documented for proper codes, modifiers, and diagnoses. By keeping encounter forms current, the coder helps ensure that all services rendered are represented, reduces missing information, and supports accurate, compliant reimbursement. This collaborative effort improves data quality and lowers the risk of claim denials. The other options describe roles outside the coder's scope—supervising staff, conducting patient intake, or negotiating insurance contracts.

**7. Which items belong on the patient information form?**

- A. The patient's social media accounts.**
- B. All pertinent insurance information and a medical release of information form.**
- C. The clinic's procurement records.**
- D. The physician's favorite color.**

Collecting patient information focuses on data needed to receive care, bill for services, and protect patient privacy. The best choice is the one that gathers all pertinent insurance information and includes a medical release of information form. Insurance details are essential for verifying coverage, determining patient responsibility, and submitting accurate claims for reimbursement. The medical release of information form is necessary to authorize sharing health records with insurers or other designated entities, ensuring compliance with privacy laws while enabling proper coordination of care and billing. Items like a patient's social media accounts are not relevant to clinical or billing purposes and could raise privacy concerns. Internal clinic records, such as procurement documents, do not belong on a patient information form. A physician's personal preference, like a favorite color, has no role in patient care, billing, or compliance. Keeping the form focused on insurance information and authorization supports accurate billing and protects patient rights.

**8. What is the standard form accepted by all health insurance companies?**

- A. CMS-1500 form**
- B. UB-04 form**
- C. CPT claim form**
- D. HCFA-1500**

Understanding standard claim forms for professional services helps explain why the CMS-1500 is the best answer. For outpatient or non-institutional billing, the form used to submit claims to almost all health plans (including private payers and Medicare/Medicaid) is the CMS-1500. This form was standardized by the Centers for Medicare & Medicaid Services and serves as the universal vehicle to relay essential claim information: patient and provider details, dates of service, diagnoses (ICD-10-CM), and procedures or services coded (CPT/HCPCS), along with charges and payment information. It's designed specifically for professional services billed by individual clinicians and groups, not for hospitals or institutional charges. The other forms reflect different billing contexts. UB-04 is the standard for institutional claims (hospitals, skilled nursing facilities, etc.), so it isn't the universal form for all providers. A CPT claim form isn't a formal form at all—CPT refers to the coding system used on claims, not the submission document. HCFA-1500 is simply an older name for the same form now commonly called CMS-1500, so the current standard widely accepted is CMS-1500.

**9. Which component is typically required to process a claim?**

- A. The patient's clinical notes.**
- B. The physician's personal preferences.**
- C. Details of services provided and associated costs.**
- D. Information on the patient, the insurer, and the services and charges.**

Processing a claim relies on data that identify who is being billed, who will pay, and what was done. The best answer includes information on the patient, the insurer, and the services and charges. This combination lets the payer match the claim to the patient's record, apply the correct benefit plan, and determine reimbursement based on the coded services and associated costs. Without patient identifiers and payer details, the claim can't be attached to the right account, and without service codes and charges, the payment amount can't be calculated. Clinical notes aren't required for standard submission, and a physician's personal preferences don't influence the billing data sent to the insurer. While the details of services and costs are essential, they must be paired with patient and payer information to process a claim correctly.

**10. Which action must be taken to ensure ICD-10-CM diagnoses are captured on the CMS-1500 form?**

- A. Ensure ICD-10-CM diagnoses are entered in Block 21.**
- B. Enter only the primary diagnosis in Block 18.**
- C. Leave Block 21 blank if the patient has a diagnosis.**
- D. Enter the patient's SSN in Block 21.**

ICD-10-CM diagnoses belong in Block 21 because this field is specifically designated for listing the diagnoses that justify the services on the claim. Entering the codes here ensures the payer has the clinical basis for the encounter and can properly process the reimbursement. You can list multiple diagnoses in Block 21, typically starting with the primary diagnosis and adding secondaries as needed, so the complete diagnostic justification travels with the claim. Placing diagnoses elsewhere, or leaving Block 21 blank, would fail to provide the necessary diagnostic information and can lead to claim denial. Also, Block 21 is not for personal identifiers like the patient's SSN; that would be inappropriate and a privacy risk.

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## 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://medicalbillingreimbursement.examzify.com>**

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

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