

Medical Insurance Practice Test (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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Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	6
Answers	9
Explanations	11
Next Steps	17

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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

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1. Box 21 of the CMS-1500 form is used for what purpose?

- A. Submitting payment information**
- B. Reporting diagnosis (Dx) codes**
- C. Indicating patient copayment**
- D. Providing the physician's details**

2. What does the schedule of benefits outline?

- A. Claim denials**
- B. Medical services covered under the insured's policy**
- C. Insurance policy renewal terms**
- D. Patient eligibility criteria**

3. How is Medicare Part B primarily funded?

- A. Through employer contributions**
- B. By premiums paid through Social Security deductions**
- C. Via state government budgets**
- D. Directly by beneficiaries without any deductions**

4. What is included as "preventive care" under the Affordable Care Act (ACA)?

- A. Surgeries needed for chronic conditions**
- B. Emergency room visits for accidents**
- C. Services aimed at preventing illness, like vaccinations and screenings**
- D. Physical therapy for injury recovery**

5. What does Secondary Insurance provide?

- A. Benefits before primary insurance**
- B. Additional coverage for services after the primary insurance has paid**
- C. Coverage for cosmetic procedures only**
- D. Exclusive benefits for dependents**

6. How do Health Maintenance Organizations (HMOs) primarily deliver their services?

- A. By allowing members to choose any provider**
- B. By creating networks of healthcare providers**
- C. By providing services on a fee-for-service basis**
- D. By using only out-of-network providers**

7. What is a physician's responsibility in the claims process?

- A. To manage patient appointments**
- B. To ensure claims are submitted on time**
- C. To sign claims for medical services rendered**
- D. To inform patients about their insurance options**

8. Who qualifies as providers in the context of medical insurance?

- A. Insurance companies and brokers**
- B. Only physicians**
- C. Physicians, hospitals, and other suppliers that furnish patient care or supplies**
- D. Patients and their families**

9. What is considered the payer of last resort in medical insurance?

- A. Medicare**
- B. Private insurance**
- C. Medicaid**
- D. Worker's Compensation**

10. What is the main purpose of a peer review in health insurance?

- A. To assess insurance claims for errors**
- B. To evaluate the quality and appropriateness of medical care decisions made by providers**
- C. To ensure compliance with state insurance regulations**
- D. To verify a patient's eligibility for coverage**

Answers

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

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Explanations

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1. Box 21 of the CMS-1500 form is used for what purpose?

- A. Submitting payment information**
- B. Reporting diagnosis (Dx) codes**
- C. Indicating patient copayment**
- D. Providing the physician's details**

Box 21 of the CMS-1500 form is specifically designated for reporting diagnosis (Dx) codes. This section allows healthcare providers to indicate the specific diagnosis related to the services rendered during the patient encounter. Accurate diagnosis coding is crucial for several reasons. It ensures that the claim is processed correctly and that the payer understands the clinical reasons for the provided services. These codes affect the reimbursement rates and validate the medical necessity of the procedures performed. Moreover, precise reporting in Box 21 can also impact quality measures and the overall assessment of care provided by the healthcare professional. By filling out this box correctly, providers can facilitate better communication with insurance companies, ensuring appropriate claims processing and avoiding potential denials due to insufficient information regarding the patient's condition.

2. What does the schedule of benefits outline?

- A. Claim denials**
- B. Medical services covered under the insured's policy**
- C. Insurance policy renewal terms**
- D. Patient eligibility criteria**

The schedule of benefits serves as a crucial document in a medical insurance policy, detailing the specific medical services and treatments that are covered under the insured's plan. This summary allows policyholders to understand the range of healthcare services they can avail themselves of with their insurance, including hospital stays, outpatient services, diagnostic tests, and preventative care. By outlining these benefits clearly, patients can make informed decisions about their healthcare and understand what they can expect regarding coverage for various medical needs. In contrast, claim denials relate to situations where a submitted claim for coverage has been rejected, and are not outlined in the schedule of benefits. Similarly, insurance policy renewal terms discuss how and when the coverage will be extended but do not fall under the regular benefits covered by the insurance. Patient eligibility criteria define who qualifies for the insurance but do not detail the specific services or treatments that the policy covers. Thus, option B accurately reflects the primary purpose of the schedule of benefits within a health insurance policy.

3. How is Medicare Part B primarily funded?

- A. Through employer contributions
- B. By premiums paid through Social Security deductions**
- C. Via state government budgets
- D. Directly by beneficiaries without any deductions

Medicare Part B is primarily funded by premiums paid through Social Security deductions, making this the correct choice. This program is designed to provide outpatient care, preventive services, and other essential medical services. Beneficiaries are required to pay a monthly premium for Part B, which is typically deducted directly from their Social Security benefits. This linkage ensures a stable funding source from those who are enrolled, and the amount may vary based on income. In addition to premiums, the federal government contributes general revenue to help cover the costs of the services provided under Medicare Part B, but the initial funding mechanism relies heavily on these premiums. Understanding this funding structure is crucial, as it underlines the importance of beneficiaries' participation in the program and showcases how Medicare is financed primarily through beneficiaries rather than employer contributions or state budgets.

4. What is included as "preventive care" under the Affordable Care Act (ACA)?

- A. Surgeries needed for chronic conditions
- B. Emergency room visits for accidents
- C. Services aimed at preventing illness, like vaccinations and screenings**
- D. Physical therapy for injury recovery

Preventive care under the Affordable Care Act (ACA) focuses on services designed to prevent illnesses, detect potential health issues early on, and promote overall health. This includes a variety of services such as vaccinations, screenings for conditions like cancer and diabetes, and annual wellness check-ups. The intent behind preventive care is to intervene before illnesses develop, ultimately leading to better health outcomes and reducing healthcare costs over time. Vaccinations, for instance, protect against preventable diseases, while screenings can identify issues early when they are often more treatable. This approach supports a healthier population and is a key component of the ACA, which aims to improve access to essential health services without out-of-pocket costs to patients for these necessary preventive measures.

5. What does Secondary Insurance provide?

- A. Benefits before primary insurance**
- B. Additional coverage for services after the primary insurance has paid**
- C. Coverage for cosmetic procedures only**
- D. Exclusive benefits for dependents**

Secondary insurance is designed to provide additional coverage after primary insurance has fulfilled its obligations. When an individual has both primary and secondary insurance policies, the primary insurance pays first on covered expenses. Once this payment is completed, the secondary insurance may cover additional costs that were not fully paid or that were not covered by the primary insurer, such as copayments, coinsurance, and deductibles. This function of secondary insurance is particularly beneficial in reducing out-of-pocket costs for the insured, as it can help to cover gaps in the primary policy's coverage or amounts left unpaid. Therefore, policies generally maintain that secondary insurance plays a crucial role when there are high medical expenses or when dealing with various types of healthcare services that might exceed what the primary insurance covers. The other options do not accurately reflect the role of secondary insurance. For instance, it does not provide benefits before primary insurance pays, nor is it limited to cosmetic procedures or exclusive benefits for dependents. These aspects speak to the nature of primary insurance or other specialized forms of coverage instead.

6. How do Health Maintenance Organizations (HMOs) primarily deliver their services?

- A. By allowing members to choose any provider**
- B. By creating networks of healthcare providers**
- C. By providing services on a fee-for-service basis**
- D. By using only out-of-network providers**

Health Maintenance Organizations (HMOs) primarily deliver their services by creating networks of healthcare providers. This model is designed to control costs and ensure the quality of care by establishing relationships with a select group of doctors, hospitals, and specialists. Members of an HMO typically must choose a primary care physician (PCP) from the network who serves as a gatekeeper for additional medical services. By using a network of providers, HMOs can negotiate lower rates for services and manage patient care more effectively, fostering coordinated treatment among providers. This structure incentivizes preventive care and wellness, as members are encouraged to use the network's services for routine visits, screenings, and health education programs, ultimately aiming to reduce the need for more extensive and costly interventions. In contrast, the other options do not accurately reflect how HMOs operate. For instance, allowing members to choose any provider is more characteristic of Preferred Provider Organizations (PPOs), while fee-for-service arrangements are associated with traditional insurance models rather than the integrated care approach of HMOs. Additionally, relying solely on out-of-network providers contradicts the fundamental premise of an HMO, which is to ensure care is received from a defined network to control costs and maintain provider relationships.

7. What is a physician's responsibility in the claims process?

- A. To manage patient appointments**
- B. To ensure claims are submitted on time**
- C. To sign claims for medical services rendered**
- D. To inform patients about their insurance options**

In the claims process, a physician's responsibility significantly includes signing claims for medical services rendered. This step is crucial because it validates that the services were provided by the physician and that they meet the standards required for billing. The physician's signature serves as an assurance to insurance companies that the claim is legitimate and that the treatments invoiced were indeed performed. This contributes to the integrity of the billing process and helps prevent fraud. While managing patient appointments and informing patients about their insurance options are important aspects of a physician's practice, they are not directly related to the claims process. Similarly, ensuring claims are submitted on time falls within the purview of administrative staff or billing departments rather than the physician themselves. Thus, the responsibility of signing claims is a key part of the physician's role in ensuring that proper protocol is followed in the reimbursement process for medical services provided.

8. Who qualifies as providers in the context of medical insurance?

- A. Insurance companies and brokers**
- B. Only physicians**
- C. Physicians, hospitals, and other suppliers that furnish patient care or supplies**
- D. Patients and their families**

In the context of medical insurance, providers refer to individuals or entities that offer medical services, healthcare supplies, or patient care. This includes a broad range of service providers that play a vital role in delivering healthcare. Physicians and hospitals are primary examples, as they are directly involved in diagnosing, treating, and caring for patients. Additionally, other suppliers can include physical therapists, pharmacies, and laboratories that provide medical tests and treatments, all of which are essential components of the healthcare system responsible for patient care. Thus, the definition of providers encompasses not just physicians but also any institution or individual that supplies necessary medical services or items, reflecting the comprehensive nature of healthcare delivery and the variety of actors involved in it. In this context, recognizing the contributions of all these entities is crucial for understanding how medical insurance integrates within the healthcare landscape.

9. What is considered the payer of last resort in medical insurance?

- A. Medicare**
- B. Private insurance**
- C. Medicaid**
- D. Worker's Compensation**

Medicaid is considered the payer of last resort in medical insurance. This designation means that when an individual has multiple sources of coverage, Medicaid will only cover medical expenses that are not paid by other insurers. This policy is in place to minimize costs to Medicaid and to ensure that federal and state resources are preserved for those who truly need them. For example, if an individual is eligible for both Medicaid and another insurance plan, services will first be billed to the other insurance provider. Only after those claims have been processed and any payment (or denial) has been made will Medicaid step in to cover any remaining costs, ensuring that their funding is used efficiently and effectively. The other options, such as Medicare, private insurance, and worker's compensation, do not hold the same designation. Medicare serves senior citizens and certain disabled individuals, while private insurance is based on individual or employer plans. Worker's compensation is specifically for work-related injuries and illnesses. Each of these pays first when applicable, establishing Medicaid's unique role as the last payer in sequence.

10. What is the main purpose of a peer review in health insurance?

- A. To assess insurance claims for errors**
- B. To evaluate the quality and appropriateness of medical care decisions made by providers**
- C. To ensure compliance with state insurance regulations**
- D. To verify a patient's eligibility for coverage**

The main purpose of a peer review in health insurance is to evaluate the quality and appropriateness of medical care decisions made by providers. This process involves the assessment of clinical decisions and practices by other qualified professionals in the same field. It helps to ensure that the care provided is evidence-based, meets established standards, and aligns with best practices. Peer reviews contribute to maintaining high standards of care by providing a structured way for healthcare professionals to review their colleagues' clinical practices. By identifying potential areas for improvement or confirming the effectiveness of treatments, peer reviews play a crucial role in enhancing patient safety and outcomes. This systematic evaluation can lead to modifications in practice that improve the quality of care delivered and can also provide insights into whether the care aligns with the guidelines set by insurance providers. In contrast, the other options focus on different aspects of the administrative or regulatory side of health insurance. Assessing insurance claims for errors relates more to the processing and approval of claims rather than direct quality assessment. Ensuring compliance with state insurance regulations pertains to the legal and operational standards that insurance companies must follow. Verifying patient eligibility for coverage is crucial for enrollment and claims processing but does not address the quality of medical care itself. Thus, choosing the evaluation of medical care decisions aligns with the primary

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://medicalinsurance.examzify.com>

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

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