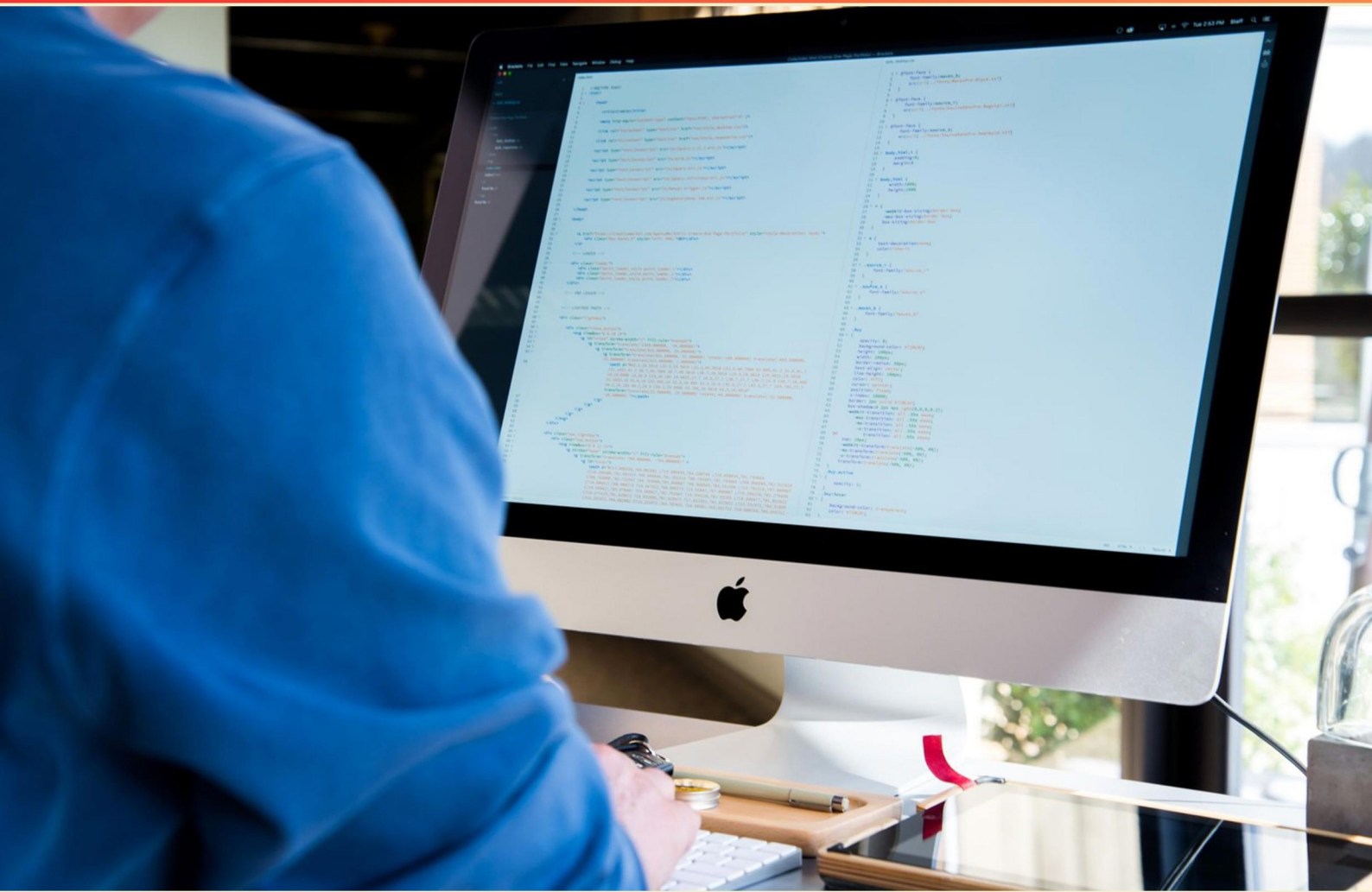


NHA CERTIFIED BILLING AND CODING SPECIALIST (CBCS) PRACTICE EXAM (SAMPLE) STUDY GUIDE



Prepare with structure. Pass with confidence



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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. In billing terms, what term describes the amount the policyholder owes the provider after all other payments are applied?**
 - A. Cost sharing
 - B. Surcharge
 - C. Fee Schedule
 - D. Discount

- 2. The patient's birth date on the CMS-1500 claim form is entered in what format?**
 - A. MM/DD/YYYY
 - B. DD/MM/YYYY
 - C. YYYY-MM-DD
 - D. YYYY/MM/DD

- 3. Which statement best defines claim adjudication?**
 - A. It is the process of appealing a denial
 - B. It is the payer's determination of the payment amount after reviewing the claim
 - C. It is the initial submission of a claim
 - D. It is the collection of payments from a patient

- 4. In radiology coding, what term describes the portion of the service that reflects the radiologist's interpretation?**
 - A. Professional component
 - B. Technical component
 - C. Global component
 - D. Supportive component

- 5. Which symbol indicates an add-on code?**
 - A. Plus sign
 - B. Bullseye
 - C. Bullet
 - D. Triangle

- 6. Blocks 14 through 33 on the CMS-1500 claim form primarily report which information?**
- A. The patient's condition and the provider's information
 - B. The patient's insurance details
 - C. The service codes and modifiers
 - D. The facility information
- 7. An organization that initiated the development of ICD codes is?**
- A. WHO
 - B. CDC
 - C. AMA
 - D. NIH
- 8. Which CMS initiative is designed to detect inappropriate coding and ensure proper code use?**
- A. National Correct Code Initiative (NCCI)
 - B. HIPAA
 - C. ICD-10-CM
 - D. CPT Editorial Panel
- 9. Block 32 on CMS-1500 is used to capture which type of information?**
- A. Service facility location information
 - B. Provider's contact details
 - C. Patient's employment
 - D. Service date range
- 10. If you witness unethical conduct by a colleague, what action is appropriate?**
- A. Report the incident to a supervisor
 - B. Confront the colleague publicly
 - C. Ignore the situation
 - D. Document privately and do nothing

Answers

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

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Explanations

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1. In billing terms, what term describes the amount the policyholder owes the provider after all other payments are applied?

- A. Cost sharing**
- B. Surcharge
- C. Fee Schedule
- D. Discount

Cost sharing is the portion of healthcare costs that the insured must pay after the insurer has paid its share. It includes the deductible, copayment, and coinsurance that the policyholder is responsible for under the plan. After the insurer's payment and any plan adjustments are applied to the bill, the remaining amount the patient owes falls under cost sharing. This distinguishes it from a surcharge (an extra fee), a fee schedule (the listed prices for services), or a discount (a reduction in price).

2. The patient's birth date on the CMS-1500 claim form is entered in what format?

- A. MM/DD/YYYY**
- B. DD/MM/YYYY
- C. YYYY-MM-DD
- D. YYYY/MM/DD

Dates of birth on the CMS-1500 claim form are entered in the US standard month/day/year format, using four digits for the year and separated by slashes. This means something like 04/12/1985. This convention avoids ambiguity for month and day order and keeps the year clear across centuries, which is important for patient identification and eligibility checks on a national form. The other formats would swap month and day (day/month/year), or place the year first (year/month/day), or use different separators (such as dashes) that aren't part of the CMS-1500 design. Therefore, the correct format is MM/DD/YYYY.

3. Which statement best defines claim adjudication?

- A. It is the process of appealing a denial
- B. It is the payer's determination of the payment amount after reviewing the claim**
- C. It is the initial submission of a claim
- D. It is the collection of payments from a patient

Adjudication is the payer's determination of the payment amount after reviewing the claim. After a claim is submitted, the payer's system checks that the patient is eligible, the service is covered under the benefit plan, and the codes (CPT/HCPCS and ICD) are appropriate and medically necessary. The payer then applies the plan's rules—benefits, deductible, coinsurance, copays, and any contract adjustments—to calculate the allowed amount. What remains the patient's responsibility is determined (if any) and the payer decides whether to pay in full, pay a portion, or deny the claim with a reason. The result of this process is the Explanation of Benefits and any payment issued. This is distinct from simply submitting a claim, appealing a denial, or collecting payment from the patient.

4. In radiology coding, what term describes the portion of the service that reflects the radiologist's interpretation?

A. Professional component

B. Technical component

C. Global component

D. Supportive component

In radiology coding, the radiologist's interpretation is the professional component. This part covers the physician's expertise—reading the images, forming the diagnosis, and producing the report. The technical component covers image acquisition, equipment use, and technologist time, while the global component combines both the professional and technical elements into a single charge. Some scenarios bill the professional and technical components separately, often using specific modifiers, but the interpretation itself remains the professional component. The term that describes the portion reflecting the radiologist's interpretation is the professional component.

5. Which symbol indicates an add-on code?

A. Plus sign

B. Bullseye

C. Bullet

D. Triangle

In CPT coding, add-on codes describe extra procedures or services performed in addition to a primary procedure. The symbol used to indicate these add-on codes is the plus sign (+) placed before the code. This signals that the code should be appended to a qualifying base code and cannot be reported by itself. The other symbols shown do not carry this meaning and are not used to mark add-on codes.

6. Blocks 14 through 33 on the CMS-1500 claim form primarily report which information?

A. The patient's condition and the provider's information

B. The patient's insurance details

C. The service codes and modifiers

D. The facility information

Blocks that cover the middle portion of the CMS-1500 are focused on the clinical encounter: they document the patient's condition in the form of diagnoses and identify who provided or referred the service. This is where you link what happened medically to the person who delivered care. You'll find fields for the illness or injury being treated, dates related to the condition and the service, and the physician or other provider details along with the codes that describe the services performed (diagnosis codes and procedure codes with any modifiers). Because of this, the primary information captured in these sections centers on why care was needed (the patient's condition) and who provided or referred the care (the provider's information). Other areas of the form handle demographics, insurance details, and billing specifics, but blocks 14 through 33 are where the clinical rationale and the provider identity come together for processing the claim.

7. An organization that initiated the development of ICD codes is?

- A. WHO**
- B. CDC
- C. AMA
- D. NIH

ICD codes exist to provide a single international system for classifying diseases and health conditions, which allows consistent reporting and comparison of health data worldwide. This coding system was started by the World Health Organization, which oversees the ICD project and guides its revisions for global use. While agencies like the CDC and professional groups later adopt and adapt ICD codes for national reporting and billing, the origin of the ICD coding system is the World Health Organization. So the organization that initiated the development of ICD codes is the World Health Organization.

8. Which CMS initiative is designed to detect inappropriate coding and ensure proper code use?

- A. National Correct Code Initiative (NCCI)**
- B. HIPAA
- C. ICD-10-CM
- D. CPT Editorial Panel

The testing focus here is on a CMS program that actively limits improper billing by checking how codes are used together. The National Correct Coding Initiative is designed for this purpose. It publishes edits that flag or deny certain CPT/HCPCS code pairings when billed on the same claim line unless a legitimate medical justification or a specific modifier is applied. This helps prevent improper payments and promotes proper coding practices across Medicare and many other payers. Unlike HIPAA, which governs privacy and data standardization, or ICD-10-CM, which is a diagnosis coding system, or the CPT Editorial Panel, which develops CPT codes, this CMS initiative specifically targets the correctness of code pair usage and billing practices.

9. Block 32 on CMS-1500 is used to capture which type of information?

- A. Service facility location information**
- B. Provider's contact details
- C. Patient's employment
- D. Service date range

Block 32 captures the service facility location—the specific clinic, hospital, or place where the patient received care. This includes the facility's name and address so the payer knows exactly where the service occurred and can route or audit the claim accordingly. It isn't used for the provider's personal contact details, the patient's employment information, or the dates of service (those belong in other sections of the form).

10. If you witness unethical conduct by a colleague, what action is appropriate?

A. Report the incident to a supervisor

B. Confront the colleague publicly

C. Ignore the situation

D. Document privately and do nothing

When you witness unethical conduct, your responsibility is to escalate the concern through the proper channels so it can be reviewed and addressed. Reporting the incident to a supervisor or appropriate authority within the organization ensures there is a formal investigation, protects patient safety, and upholds professional standards. It also provides a clear, documented path for accountability and any necessary corrective action, while allowing protections under workplace policies. Confronting the colleague publicly undermines professionalism, can escalate tension, and may jeopardize patient safety without giving the issue a fair, documented review. Ignoring the situation or merely documenting privately and doing nothing leaves the behavior unchecked and potential harm unaddressed, which is not acceptable in a healthcare setting.

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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.

Or visit your dedicated course page for more study tools and resources:

<https://nhacbs.examzify.com>

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

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