Member ID: _____

Time: _____

Rank: _____

BUSINESS PROFESSIONALS of AMERICA
Giving Purpose to Potential

Health Insurance & Medical Billing

(605)

REGIONAL 2025

CONCEPT KNOWLEDGE:

Multiple Choice (15 @ 2 points each) _____ (30 points)

Matching (10 @ 2 points each) _____ (20 points)

APPLICATION KNOWLEDGE:

Form Completion (50 @ 1 point each) _____ (50 points)

TOTAL POINTS: _____ (100 points)

Test Time: 60 minutes

GENERAL GUIDELINES:

Failure to adhere to any of the following rules will result in disqualification:

1. Participant must hand in this test booklet and all printouts, if any.

2. No equipment, supplies, or materials other than those specified for this event are allowed in the testing area. No previous BPA tests and/or sample tests (handwritten, photocopied, or keyed) are allowed in the testing area.

3. Electronic devices will be monitored according to ACT standards.

Directions: Identify the letter of the choice that best completes the statement or answers the question.

1. What is the purpose of a clearing house in healthcare billing?
    A. Clearinghouses verify patient eligibility for insurance
    B. Clearinghouses convert claims data into standard formats and check for errors
    C. Clearinghouses handle patient billing inquiries
    D. Clearinghouses manage insurance company requirements

2. What types of commerical health insurance plans are commonly structured for group-sponsored coverage?
    A. Health Savings Accounts (HSAs)
    B. Preferred Provider Organizations (PPOs)
    C. Medicaid
    D. Medicare

3. What does the term “birthday rule” refer to in health insurance coordination?
    A. The day when insurance begins for a newborn
    B. The age at which insurance premiums increase
    C. The deadline for submitting insurance claims
    D. The rule to determine which parent’s insurance is primary for dependent coverage

4. Why is accurate insurance verification crucial for medical billing?
    A. Insurance verification ensures timely reimbursement
    B. Insurance verification helps healthcare providers accurately track and manage their revenue cycle
    C. Insurance verification maintains compliance with regulatory requirements and reduces the risk of audits
    D. Insurance verification helps healthcare providers determine the patient’s financial responsibility

5. What are the main differences between a preferred provider organization (PPO) and a health maintenance organization (HMO) in terms of patient access and coordination of care?
    A. PPOs require referrals, while HMOs do not
    B. PPOs allow patients to go outside the network, while HMOs do not
    C. HMOs are group plans, while PPOs are individual plans
    D. HMOs cover preventative care, while PPOs cover emergencies

6. How does commercial health insurance differ from government-run programs like Medicaid and Medicare?
    A. Commercial health insurance is provided by nonprofit carriers
    B. Commercial health insurance covers preventive care only
    C. Government-run programs have standardized claims processes
    D. Commercial health insurance is administered by nongovernmental entities

7. What is the primary objective of standardizing the claims process in healthcare?
    A. To reduce inefficiencies and prevent fraud
    B. To eliminate the need for insurance verification
    C. To simplify billing for patients
    D. To ensure equal coverage for all patients

8. What is the purpose of designating a guarantor in the medical billing process?
    A. To assign responsibility for providing medical treatment to patients
    B. To ensure proper documentation of patient medical records
    C. To identify the individual or entity responsible for paying medical bills
    D. To facilitate communication between healthcare providers and insurance companies

9. What steps are involved in processing payments received in a medical office?
    A. Collecting payment, issuing refunds, and depositing funds into the office's bank account
    B. Verifying insurance coverage, generating invoices, and billing patients for outstanding balances
    C. Entering patient details into the accounting system, reconciling accounts, and updating patient records
    D. Negotiating payment terms with patients, tracking payment schedules, and sending payment reminders

10. In medical terminology, what does the abbreviation "CPT" stand for?
    A. Critical Patient Treatment
    B. Current Procedural Terminology
    C. Clinical Practice Testing
    D. Clinical Patient Tracking

11. In medical terminology, what does the abbreviation "ICD" refer to?
    A. Intensive Care Documentation
    B. Immediate Care Directive
    C. International Classification of Disease
    D. International Clinical Documentation

12. In medical billing, who is typically listed as the guarantor for a 10-year-old patient?
    A. The patient
    B. The patient's legal guardian or parent
    C. The attending physician
    D. The referring physician

13. Which type of insurance provides income replacement if an individual is unable to work due to a temporary disability caused by illness or injury?
    A. Long-term care insurance
    B. Health insurance
    C. COBRA
    D. Disability insurance

14. Which type of health insurance plan typically allows members to choose healthcare providers both inside and outside of a network, without requiring referrals for specialty care?
    A. Preferred Provider Organization (PPO)
    B. Health Maintenance Organization (HMO)
    C. Exclusive Organization (EPO)
    D. Point of Service (POS)

15. How does an Explanation of Benefits (EOB) assist patients in understanding their healthcare expenses?
    A. By providing a summary of medical services provided to a patient
    B. By explaining the terms and conditions of an insurance policy
    C. By outlining the costs covered and not covered by an insurance plan for specific medical services provided to a patient
    D. By notifying patients of upcoming appointments and procedures

Matching: Match the term or abbreviation with the best definition.

_____ 1. NPI

_____ 2. EDI

_____ 3. Clearinghouse

_____ 4. ICD-10-CM

_____ 5. ICD-10-PCS

_____ 6. CPT

_____ 7. HCPCS

_____ 8. UB-04

_____ 9. DRG

_____ 10. RA

A. A coding system used to report medical services and supplies for billing purposes, including durable medical equipment, prosthetics, and certain drugs.
B. A coding system used to classify and code diagnoses in healthcare settings.
C. An electronic exchange of healthcare information in a standardized format, as mandated by HIPAA for covered entities.
D. A standard claim form used by hospitals and other institutional providers for billing insurance companies for healthcare services.
E. A system used to code procedures performed in hospital inpatient settings.
F. A classification system used to categorize patients into groups based on diagnosis, procedures, age, sex, and other criteria for the purpose of determining Medicare reimbursement.
G. A unique identification number for covered healthcare providers, required by HIPAA for standard transactions.
H. A medical code set used to report outpatient medical procedures and services performed by healthcare providers.
I. An entity that processes and submits healthcare claims electronically on behalf of healthcare providers to insurance payers.
J. A document sent by a payer to a provider that outlines the details of payment for healthcare services rendered.

Application Knowledge

***Instructions**: Review the medical office documentation below and complete the Health Insurance Claim Form on the following page using the information provided as if you are preparing a claim for the primary insurance. Please note that some items on the claim form may be left blank and some information may be required in multiple spaces. When the form is complete, sign the provider's name and enter today's date on the form.*

ABC Physicians Group
1000 Charleston Ave, Springfield, WI 61116

505-863-2471
FEIN 765285461

Patient Name: William S Johns
Address: 123 Circle Drive, Anytown, WI 62321
Gender: Male

Date of Birth: 08/21/2006
Phone Number: 505-510-3389
Account Number: 918273

Primary Insurance Provider: Cigna
Insurance Provider Address: PO Box 7003, Salt Lake City, UT 43301
Member ID Number: 6712576-03
Primary Group Name: Cigna
Policy Holder: Samanth A Johns
Address: 123 Circle Drive, Anytown, WI 62321
Relationship to Patient: Mother

Primary Group Number: H52463
Subscriber ID Number: 6712576-01
Policy Holder DOB: 02/27/1968
Phone Number: 505-510-3389

Referring Physician: Samuel Jennings, MD, NPI 9568735210

Date of Service: 10/21/2024

Rendering Physician: Jason W Greenday, MD, NPI 9458375180

Diagnosis: Pneumonia, J18.9
Onset of illness: 10/16/2024

Services Provided
Outpatient visit, established patient, high level MDM, 99215……...…$125
Test for Influenza virus, DNA/RNA, 87502……....$45
Chest x-ray, 2 views, 71046…….$60

Patient was seen at this location.
Patient paid…….$0

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE

OMB No. 1240-0044
Expires: 06/30/2024

1. ☐ MEDICARE (Medicare#) ☐ MEDICAID (Medicaid#) ☐ TRICARE (ID#/DoD#) ☐ CHAMPVA (Member ID#) ☐ GROUP HEALTH PLAN (ID#) ☐ FECA BLK LUNG (ID#) ☐ OTHER (ID#)		1a. INSURED I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last, First, Middle Initial)	3. PATIENT'S BIRTH DATE SEX ☐M ☐F	4. INSURED'S NAME (Last, First, Middle Initial)
5. PATIENT'S ADDRESS (Street, City, State, Zip)	6. PATIENT RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Child ☐ Other	7. INSURED'S ADDRESS (Street, City, State, Zip)
TELEPHONE (Include Area Code):	8. RESERVED FOR NUCC USE	TELEPHONE (Include Area Code):
9. OTHER INSURED'S NAME (Last, First, Middle Initial)	10. PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ Yes ☐ No	a. INSURED'S DATE OF BIRTH SEX ☐M ☐F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) ☐ Yes ☐ No	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ Yes ☐ No	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. PATIENT'S PLAN OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ Yes ☐ No *If yes, complete items 9, 9a, and 9d.*
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.. SIGNED _____
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) QUAL.	15. OTHER DATE QUAL.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM: TO:
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM: TO:
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ Yes ☐ No $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24e) ICD Ind. ☐ A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PATIENT AND INSURED INFORMATION

24. A. DATE(S) OF SERVICE From To	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPSCS	MODIFIER	E. DIAGNOSIS POINTER (A-L)	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER NPI #
									NPI	
									NPI	
									NPI	
									NPI	
									NPI	
									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ Yes ☐ No	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____	32. SERVICE FACILITY LOCATION INFORMATION a. b.	33. BILLING PROVIDER INFO & PH # a. b.

PHYSICIAN OR SUPPLIER INFORMATION