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

Multiple Choice

1.	B
2.	B
3.	D
4.	A
5.	B
6.	D
7.	A
8.	C
9.	C
10.	B
11.	C
12.	B
13.	D
14.	A
15.	C

Matching

1.	G
2.	C
3.	I
4.	B
5.	E
6.	H
7.	A
8.	D
9.	F
10.	J

Grader Instructions for Application Components

Form Completion
Review the Health Insurance Claim Form completed by participants and compare with key below. Each box is worth 1 point, if errors are present or information is missing, deduct a point from the total. For example, Box 1a requires the Insured's ID number, if this number is missing or incorrect, deduct one point.

Each box to be evaluated is numbered. Any boxes not numbered should not be evaluated.

Notes to Graders
Instructional notes are provided on the key to indicate when multiple boxes should be considered together as a point. In these cases, all elements must be correct for credit to be provided.

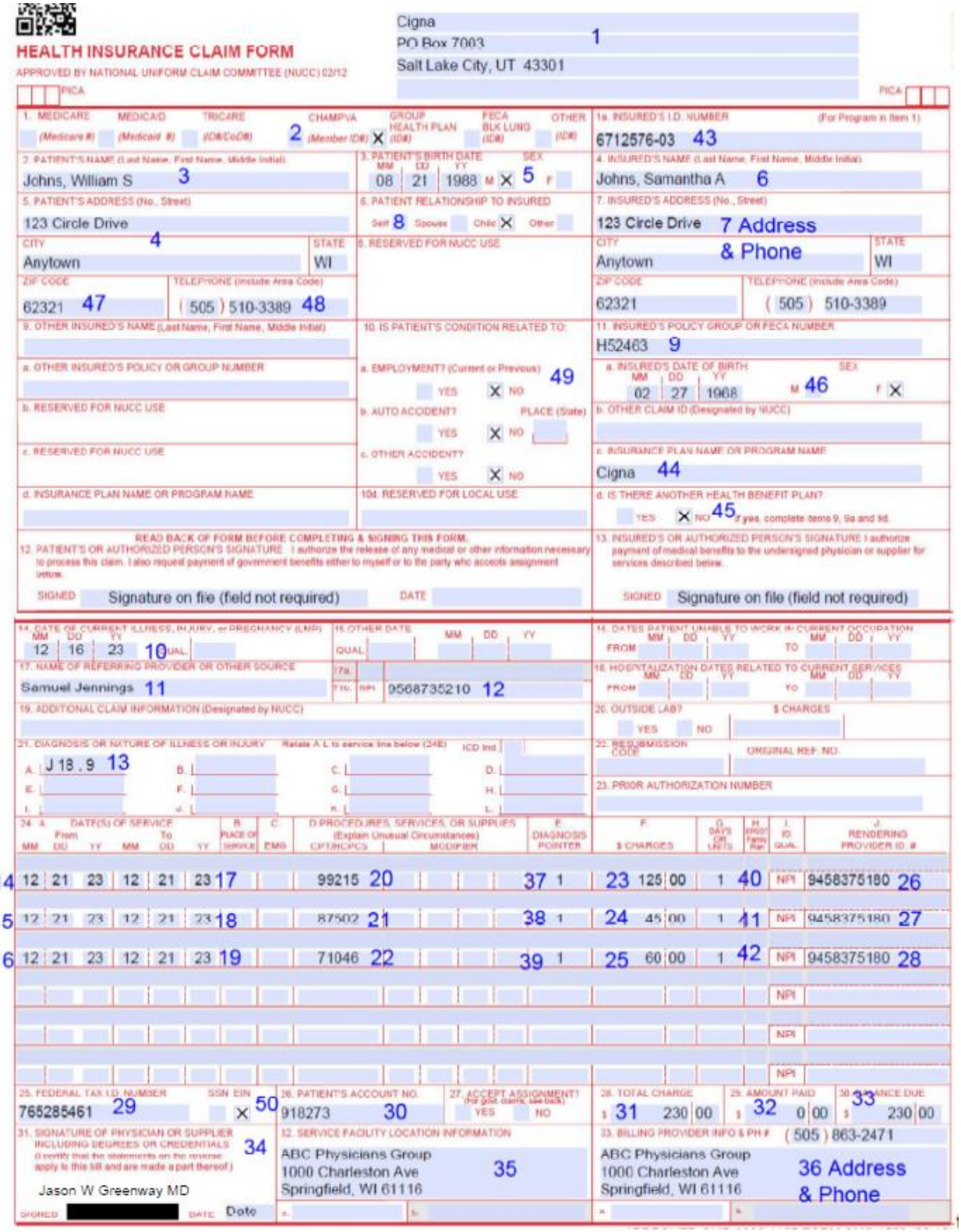
Box 24: These rows can be provided in any order, however, the data in each row must be correct.

Box 24a – From Date (one for each row)

Box 24b – To Date (one for each row)

Box 33 – The "Name" in this box can be provider name or the name of the practice. Either are acceptable.

There are fields on the claim form where multiple formats may be acceptable. If you have a question on a particular field, please reference the NUCC Health Insurance Claim Form Instruction Manual, located here:
https://www.nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2023_07-v11.pdf



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Cigna
PO Box 7003 1
Salt Lake City, UT 43301

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) 2 X GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 6712576-03 43

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Johns, William S 3

3. PATIENT'S BIRTH DATE: 08 21 1988 SEX: M X 5 F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Johns, Samantha A 6

5. PATIENT'S ADDRESS (No., Street): 123 Circle Drive

6. PATIENT RELATIONSHIP TO INSURED: Self 8 Spouse Child X Other

7. INSURED'S ADDRESS (No., Street): 123 Circle Drive 7 Address

CITY: Anytown 4 STATE: WI

8. RESERVED FOR NUCC USE

CITY: Anytown & Phone STATE: WI

ZIP CODE: 62321 47 TELEPHONE (Include Area Code): (505) 510-3389 48

ZIP CODE: 62321 TELEPHONE (Include Area Code): (505) 510-3389

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: H52463 9

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES X NO 49

a. INSURED'S DATE OF BIRTH: 02 27 1968 SEX: M 46 F X

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES X NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: Cigna 44

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO 45 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: Signature on file (field not required) 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: Signature on file (field not required)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 12 16 23 10 QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Samuel Jennings 11

17a. 17b. NPI 9508735210 12

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY 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. J 18 . 9 13 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
14 12 21 23	12 21 23 17			99215 20		37 1	23 125 00	1 40		NPI	9458375180 26
15 12 21 23	12 21 23 18			87502 21		38 1	24 45 00	1 41		NPI	9458375180 27
16 12 21 23	12 21 23 19			71046 22		39 1	25 60 00	1 42		NPI	9458375180 28
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: 765285461 29 SSN EIN X 50

26. PATIENT'S ACCOUNT NO.: 918273 30

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE: $ 31 230 00

29. AMOUNT PAID: $ 32 0 00

30. BALANCE DUE: $ 33 230 00

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.) 34

Jason W Greenway MD

SIGNED [redacted] DATE: Date

32. SERVICE FACILITY LOCATION INFORMATION: ABC Physicians Group 1000 Charleston Ave Springfield, WI 61116 35

33. BILLING PROVIDER INFO & PH #: (505) 863-2471

ABC Physicians Group 1000 Charleston Ave Springfield, WI 61116 36 Address & Phone