COMPLETING THE UB-04 CLAIM FORM – INTRODUCTION PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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.

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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!

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Questions

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1. Which field records the total charges the provider expects to be paid?

A. Non-covered charges

B. Prior payments

C. Total charges

D. Health Plan ID

2. What are typical file formats for UB-04 claim submission?

A. HIPAA-compliant formats such as X12 5010 837; UB-04 may be the 837I; submission can be electronic or paper.

B. Only printed paper UB-04 forms.

C. PDF submissions only.

D. Email submissions only.

3. Which item is typically included in the UB-04 header to describe payer or payer edits?

A. Payer information

B. Diagnosis pointers

C. Value Codes

D. Occurrence Codes

4. Which code type corresponds to a trauma patient at a trauma center or hospital?

A. 1 - Emergency

B. 5 - For trauma patients at trauma center or hospital

C. 2 - Urgent

D. 3 - Planned elective

5. UB-04 claim form is also known as CMS-1450. Which CMS form name corresponds to this form?

A. CMS-1450

B. CMS-1500

C. ICD-10-PCS

D. NUBC

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6. What is the National Provider Identifier (NPI)?

A. A four-digit code used to indicate payer type.

B. A ten-digit identifier used to track patient visits.

C. A standard ten-digit identifier for health care providers.

D. A code used for facility accreditation.

7. What is the difference between inpatient and outpatient claims on UB-04?

A. Inpatient claims (TOB 11x or 12x) cover longer hospital stays; outpatient claims (TOB 13x, 22x) cover services not requiring admission

B. Inpatient claims are always paid first

C. Outpatient claims require admission

D. Inpatient claims are never associated with discharge dates

8. What does the SERV. UNITS field denote on a line item?

A. The units used in the revenue code; may be days, times treated, or fluids

B. The patient's age

C. The hospital room number

D. The physician license number

9. What is the Principal Diagnosis and how is it treated on the UB-04?

A. The principal diagnosis is the main condition treated or diagnosed during the encounter; it is reported first in the diagnosis field and influences line-item pointers.

B. The principal diagnosis is the least significant diagnosis.

C. The principal diagnosis is listed after all other diagnoses.

D. The principal diagnosis has no impact on payment.

10. What does the 'Statement covers period' field indicate?

A. The time frame of the service period billed

B. The date of birth

C. The hospital's fiscal year

D. The date of discharge

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Answers

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

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Explanations

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1. Which field records the total charges the provider expects to be paid?

A. Non-covered charges

B. Prior payments

C. Total charges

D. Health Plan ID

In UB-04 billing, you record the amount billed for the entire encounter in the total charges field. This is the gross amount the provider expects to be paid, serving as the baseline before any adjustments, discounts, or payer-specific write-offs are applied. Insurance payers use this figure to determine how much they will allow and what portion may be the patient's responsibility after benefits are applied. Non-covered charges refer to services not payable under the policy, and prior payments are amounts already paid toward the bill, while the Health Plan ID identifies the payer. None of these capture the initial billed amount as the total charges do.

2. What are typical file formats for UB-04 claim submission?

A. HIPAA-compliant formats such as X12 5010 837; UB-04 may be the 837I; submission can be electronic or paper.

B. Only printed paper UB-04 forms.

C. PDF submissions only.

D. Email submissions only.

Under HIPAA, claims are sent using standardized electronic formats, and for UB-04 this means the X12 5010 837 Institutional (837I) transaction. The paper equivalent is the UB-04 form (CMS-1450). So typical submissions can be electronic using 837I or on paper using the UB-04 form, depending on payer requirements. Formats like PDF or email aren't the standard HIPAA claim transmission formats.

3. Which item is typically included in the UB-04 header to describe payer or payer edits?

A. Payer information

B. Diagnosis pointers

C. Value Codes

D. Occurrence Codes

In the UB-04 form, the header is where payer-related information is stored. This part of the form communicates who is responsible for payment and any payer-specific handling or edits that should be applied during processing. Having the payer's identity and identifiers at the top helps ensure the claim goes to the correct payer and is adjudicated under that payer's rules. Diagnosis pointers are linked to the individual service lines to show which diagnosis supports each item, so they belong with the line-item data rather than the header. Value Codes and Occurrence Codes convey auxiliary information such as payment types or event dates, but they don't describe who the payer is or any edits applied by the payer.

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4. Which code type corresponds to a trauma patient at a trauma center or hospital?

A. 1 - Emergency

B. 5 - For trauma patients at trauma center or hospital

C. 2 - Urgent

D. 3 - Planned elective

Code type on the UB-04 claim indicates the category of the patient encounter. For a patient treated at a trauma center or hospital, you use the trauma-specific code type designated as 5. This label specifically identifies trauma cases within the trauma care pathway, which helps with payer processing and any trauma-related considerations. The other options reflect general urgency or elective status (emergency, urgent, or planned elective) and do not indicate trauma center status, so they aren't appropriate for a trauma patient at a trauma center.

5. UB-04 claim form is also known as CMS-1450. Which CMS form name corresponds to this form?

A. CMS-1450

B. CMS-1500

C. ICD-10-PCS

D. NUBC

The UB-04 is the standard institutional claim form used for hospital and facility billing, and its official CMS form name is CMS-1450. This designation comes from CMS, where CMS-1450 identifies the form used to submit facility charges. The other names refer to different things: CMS-1500 is the professional claim form used by physicians and non-institutional providers; ICD-10-PCS is the inpatient procedure coding system; NUBC is the committee that standardizes billing data and forms, not a specific form. So the form name that matches UB-04 is CMS-1450.

6. What is the National Provider Identifier (NPI)?

A. A four-digit code used to indicate payer type.

B. A ten-digit identifier used to track patient visits.

C. A standard ten-digit identifier for health care providers.

D. A code used for facility accreditation.

The National Provider Identifier is a standard ten-digit numeric ID assigned to health care providers and organizations to identify them in administrative and billing transactions. It's mandated for use in HIPAA transactions, so claims, eligibility checks, and other electronic exchanges consistently reference the correct provider. It's not a code for payer type, it doesn't track patient visits, and it isn't a credentialing or accreditation code. The purpose is simply to uniquely identify who provided or billed for the service, with both individual and organizational NPIs in use.

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7. What is the difference between inpatient and outpatient claims on UB-04?

A. Inpatient claims (TOB 11x or 12x) cover longer hospital stays; outpatient claims (TOB 13x, 22x) cover services not requiring admission

B. Inpatient claims are always paid first

C. Outpatient claims require admission

D. Inpatient claims are never associated with discharge dates

The main thing this is testing is how UB-04 uses Type of Bill codes to show whether a claim is for an inpatient stay or for outpatient services. Inpatient hospital claims use TOB codes like 11x or 12x, which signals that the patient was admitted and will have a discharge date marking the end of the stay. Outpatient claims use TOB codes such as 13x or 22x, indicating services provided without a full hospital admission, such as same-day procedures or clinic encounters, where there isn't an overnight stay. This distinction matters because inpatient claims are tied to a length of stay and a discharge date, reflecting a period of hospitalization, while outpatient claims cover services delivered without admission and are generally billed differently. Why the other ideas don't fit: inpatient claims aren't inherently paid first—the timing of payment depends on the payer and process; outpatient claims don't require admission (that's the opposite of what they describe); and inpatient claims are indeed associated with discharge dates, so saying they aren't would be incorrect.

8. What does the SERV. UNITS field denote on a line item?

A. The units used in the revenue code; may be days, times treated, or fluids

B. The patient's age

C. The hospital room number

D. The physician license number

Serv. Units shows the quantity of the billed service for that line item. It quantifies what was provided, using the unit defined by the revenue code on that line. For example, hospital room charges may use days as units, therapy services may use the number of visits or hours, and medications or infusions may use the amount dispensed (such as vials or milliliters). This field works with the unit price to determine the charge and subsequent reimbursement. It isn't related to the patient's age, the room number, or the physician's license.

9. What is the Principal Diagnosis and how is it treated on the UB-04?

A. The principal diagnosis is the main condition treated or diagnosed during the encounter; it is reported first in the diagnosis field and influences line-item pointers.

B. The principal diagnosis is the least significant diagnosis.

C. The principal diagnosis is listed after all other diagnoses.

D. The principal diagnosis has no impact on payment.

The principal diagnosis is the main condition that prompted the admission or was most directly treated or diagnosed during the encounter. On the UB-04, that code is placed first in the diagnosis field, signaling its priority over any secondary conditions. This placement matters because it helps map the services and procedures to the primary reason for the stay through line-item pointers, and it influences how the case is classified for payment (e.g., DRG considerations). The other conditions are coded as additional diagnoses, listed after the principal one, but they do not define the main reason for admission. Saying the principal diagnosis is least significant, listed after all others, or has no impact on payment would misstate how UB-04 coding and reimbursement work.

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10. What does the 'Statement covers period' field indicate?

A. The time frame of the service period billed

B. The date of birth

C. The hospital's fiscal year

D. The date of discharge

The main idea is that this field shows the dates of service being billed—the period during which the patient received care for this claim. It sets the start and end dates for the services covered by the statement, so the payer can match the charges to the medical record and the episode of care. For an outpatient visit, it may be a single date; for an inpatient stay, it typically spans from admission to discharge. This is about when the care occurred, not the patient's birth date, the hospital's fiscal year, or a standalone discharge date.

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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://completingtheub04claimformintro.examzify.com

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

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