MCBC BILLING AND COLLECTIONS PRACTICE EXAM (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. What law was designed to protect the accuracy and privacy of credit reports?

A. Fair and Accurate Credit Transaction Act

B. Health Insurance Portability and Accountability Act

C. Gramm-Leach-Bliley Act

D. Fair Credit Reporting Act

2. The day sheet serves to _____.

A. It records only cash payments

B. It lists patients

C. It tracks inventory

D. It summarizes the financial transactions that occur each day

3. What must be done with creditor claims by the bankruptcy court's deadline?

A. The claims must be filed by the date specified by the bankruptcy court.

B. Claims can be filed any time after discharge.

C. Claims are automatically approved.

D. Claims are not allowed from medical practices.

4. After the remittance advice is received, which statement is true?

A. The remittance advice is ignored

B. The payer's payment for each reported procedure is entered

C. The amount the patient owes for each reported procedure is calculated

D. If any part of a charge must be written off, that amount is entered

5. Which statement may be true regarding staff assignments and collections in a medical office?

A. Small offices may assign collection duties to coders or billers.

B. Staff assignments vary between practices

C. Both statements

D. Neither statement

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6. Who should come in periodically to audit the medical practice's finances and bookkeeping practices?

A. An outside accountant

B. Internal auditor

C. Financial consultant

D. Certified public accountant

7. Which factor is most important when evaluating a collection agency's performance?

A. The agency actively pursues payment.

B. The agency's geographic proximity.

C. The agency's advertising spend.

D. The agency's logo color.

8. When billing is done manually rather than by computer, the patient statement form is called the _____.

A. remittance advice

B. patient ledger card

C. cycle bill

D. invoice register

9. Which of the following is a recommended approach when talking to patients on the phone for collections?

A. Be straightforward and honest

B. Yell to pressure payment

C. Interrupt the patient

D. End the call abruptly if upset

10. What is the first step in the typical medical billing and collections workflow?

A. Obtain prior authorization for every service before scheduling.

B. Verify patient identity and demographics; confirm insurance eligibility and benefits before or at the time of service.

C. Prepare patient payment estimates before service.

D. Verify patient identity and demographics only after service.

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Answers

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

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Explanations

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1. What law was designed to protect the accuracy and privacy of credit reports?

A. Fair and Accurate Credit Transaction Act

B. Health Insurance Portability and Accountability Act

C. Gramm-Leach-Bliley Act

D. Fair Credit Reporting Act

The law designed to protect the accuracy and privacy of credit reports is the Fair Credit Reporting Act. This act establishes how credit information is collected, shared, and corrected, giving consumers the right to access their reports, dispute inaccuracies, and require that furnishers and reporting agencies handle information responsibly and securely. The Fair and Accurate Credit Transaction Act is an amendment to this law that adds extra protections (like free annual credit reports and identity-theft safeguards), but the foundational framework governing credit reports and their accuracy and privacy comes from the Fair Credit Reporting Act. The other options—HIPAA protects health information, and the Gramm-Leach-Bliley Act focuses on financial privacy more broadly—do not specifically govern credit report accuracy and privacy.

2. The day sheet serves to _____.

A. It records only cash payments

B. It lists patients

C. It tracks inventory

D. It summarizes the financial transactions that occur each day

The day sheet is a daily financial record that captures all money-related activity in the practice for that day. It consolidates charges, payments, adjustments, and refunds into one summary, giving a clear picture of the day's financial transactions and supporting reconciliation with cash, deposits, and the ledger. It isn't limited to cash payments, since payments come by various methods and may include adjustments. It isn't simply a list of patients, which would be a patient roster, and it isn't used for tracking inventory, which is about supplies. So the most accurate description is that it summarizes the financial transactions that occur each day.

3. What must be done with creditor claims by the bankruptcy court's deadline?

A. The claims must be filed by the date specified by the bankruptcy court.

B. Claims can be filed any time after discharge.

C. Claims are automatically approved.

D. Claims are not allowed from medical practices.

In bankruptcy, creditors must file their claims by a court-imposed deadline—the bar date. This deadline sets a clear cutoff for asserting debts against the debtor's estate, allowing the trustee and other parties to review, classify, and administer payments in an orderly way. If a creditor misses that deadline, the claim is typically barred from being paid from the estate unless the court grants an extension for good cause or another exception applies. So the best choice is that claims must be filed by the date specified by the bankruptcy court. Filing after discharge isn't the remedy, because discharge frees the debtor from many debts and late claims generally aren't payable. Claims aren't automatically approved; they require review and adjudication. And creditors aren't limited to medical practices; all valid creditors can file claims.

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4. After the remittance advice is received, which statement is true?

A. The remittance advice is ignored

B. The payer's payment for each reported procedure is entered

C. The amount the patient owes for each reported procedure is calculated

D. If any part of a charge must be written off, that amount is entered

Remittance advice is the payer's detailed notice of how much was paid and what portion, if any, remains the patient's responsibility. Once this advice arrives, the crucial step is to determine the amount the patient owes for each reported procedure so you can update the patient ledger and bill the patient accordingly. The payer's payment per procedure is part of the information you use, but the action that directly drives patient collections is calculating the patient responsibility. Ignoring the remittance advice would lead to missing payments and balances, and while adjustments or write-offs may occur, the primary immediate task shown by the remittance advice is to establish the patient's amount due for each service.

5. Which statement may be true regarding staff assignments and collections in a medical office?

A. Small offices may assign collection duties to coders or billers.

B. Staff assignments vary between practices

C. Both statements

D. Neither statement

Staffing for collections in medical offices varies with practice size and resources. In small offices, there aren't enough staff to support a separate collections team, so coders or billers often take on collection duties alongside their usual tasks. In other practices, staffing structures differ: some designate dedicated collection specialists, others assign these tasks to patient financial services staff, front desk personnel, or even outsource collections. Because practices differ in size, workflow, and resource availability, both statements can be true. That's why the best answer is that both statements may be true.

6. Who should come in periodically to audit the medical practice's finances and bookkeeping practices?

A. An outside accountant

B. Internal auditor

C. Financial consultant

D. Certified public accountant

Periodic independent verification of the practice's finances and bookkeeping is best done by an outside accountant. This external auditor provides objectivity and professional scrutiny, helping to catch errors, ensure compliance with accounting standards, and uncover potential fraud. The credibility of financial statements improves with an independent review, which is especially important for lenders, payers, and regulators. An internal auditor, while valuable for ongoing controls, is part of the practice and may not offer the same level of independence or external credibility. A financial consultant aims to advise on finances, not regularly audit records. A certified public accountant is a credential for an external reviewer, but the emphasis here is on independence from the practice to ensure an unbiased assessment.

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7. Which factor is most important when evaluating a collection agency's performance?

A. The agency actively pursues payment.

B. The agency's geographic proximity.

C. The agency's advertising spend.

D. The agency's logo color.

What matters most when evaluating a collection agency's performance is how actively it pursues payment. The primary goal of a collection agency is to recover debts, so the effectiveness of its follow-up—how often it contacts debtors, the quality and persistence of those contacts, and its ability to negotiate payment plans or secure settlements—directly drives the amount collected and the speed of recovery. This active pursuit also reflects how well the agency manages accounts, uses skip-tracing tools, and enforces appropriate actions within regulatory and privacy guidelines, all of which are central to performance. Other factors don't indicate performance in the same way. Geographic proximity might matter for in-person visits in rare cases but isn't a reliable gauge of outcomes in most modern collections. Advertising spend has no direct link to recovering debts and can distort ROI. A logo color is purely branding and has no impact on the agency's effectiveness at collecting money.

8. When billing is done manually rather than by computer, the patient statement form is called the _____.

A. remittance advice

B. patient ledger card

C. cycle bill

D. invoice register

In manual billing, each patient's transactions are tracked on a personal record that shows all charges, payments, and the running balance. This single-item record is the patient ledger card, which staff use to generate and reference paper statements for that patient. It provides a clear history of activity for an individual account, making it possible to see what's owed at a glance. Remittance advice is the payer's explanation of how a submitted claim was paid, not the patient statement itself. A cycle bill refers to sending out statements in scheduled batches, which is an automated or semi-automated process, not the actual form used to record the patient's activity. An invoice register is a log of issued invoices, typically used in business-to-business or vendor contexts, not the patient's personal ledger for medical billing.

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9. Which of the following is a recommended approach when talking to patients on the phone for collections?

A. Be straightforward and honest

B. Yell to pressure payment

C. Interrupt the patient

D. End the call abruptly if upset

Clear, respectful communication is essential when discussing patient balances over the phone. Being straightforward and honest means calmly stating the exact amount due, what charges cover, any due dates, and the payment options available. This approach builds trust, reduces confusion, and increases the likelihood that the patient will cooperate. It also supports professional and regulatory expectations by avoiding deception or pressure tactics. If a patient can't pay in full, offer legitimate options such as a feasible payment plan, alternate arrangements, or financial assistance if appropriate, and listen to any barriers they mention. Maintaining a calm tone, verifying identity, and documenting the conversation further protect the patient's privacy and your organization. Coping with the call by yelling, interrupting, or ending it abruptly undermines trust, can irritate the patient, and may lead to disputes or complaints.

10. What is the first step in the typical medical billing and collections workflow?

A. Obtain prior authorization for every service before scheduling.

B. Verify patient identity and demographics; confirm insurance eligibility and benefits before or at the time of service.

C. Prepare patient payment estimates before service.

D. Verify patient identity and demographics only after service.

The first step in medical billing and collections is to verify the patient's identity and demographics and to confirm insurance eligibility and benefits before or at the time of service. This sets the foundation for accurate billing because you're capturing who the patient is, making sure the payer knows who's being billed, and confirming what the plan covers, including copays, deductibles, and any specific benefits. With verified information and confirmed eligibility, you can determine the patient's financial responsibility upfront, avoid data errors, and reduce the likelihood of claim denials or delays. Prior authorization is important for many procedures, but it isn't required for every service and isn't universally the first step. Some services don't need preauthorization, and delaying verification to obtain authorization first can slow down scheduling and patient access. Preparing payment estimates depends on having verified benefits and the patient's eligibility details, so it follows after you confirm who's covered and what's covered. Verifying identity and demographics only after service would make it impossible to bill correctly and would lead to more post-service edits and denied claims.

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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://mcbcbillingcollections.examzify.com

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

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