Chapter 007 Billing, Reimbursement, and Collections

**Multiple Choice Questions**

1. Another name for a patient encounter form is:
A. Charge slip
B. Pink slip
C. Super Bill
D. Both A and C answers are correct

2. Forms used by the medical practice should be updated \_\_\_\_\_\_\_\_\_\_ and the codes verified with the current year's diagnostic and procedural codes.
A. Every three months
B. Monthly
C. Semi-Annually
D. Annually

3. Select the item that does not go on the patient encounter form.
A. Patient address
B. Date of service
C. Insurance
D. Previous services

4. Dr. Adams has rendered a non-covered procedure to Mrs. Johnson, who is covered by Medicare. She was not advised before the procedure that it is not covered. The medical office should:
A. Charge Mrs. Johnson for the procedure.
B. Obtain Mrs. Johnson's signature on an ABN.
C. Adjust the procedure charge off Mrs. Johnson's account.
D. Charge Mrs. Johnson the Medicare allowable amount for the service.

5. An appointment was scheduled for a new patient, who asked how much the fee would be for the visit. The administrative medical assistant should:
A. Quote the highest new patient exam fee to the patient.
B. Transfer the call to the office manager.
C. Quote the mid-level new patient exam fee to the patient.
D. Provide an estimate of the exam but explain that the estimate is prior to other services, such as blood work.

6. Hardcopy insurance claim forms will produce which of the following?
A. ERA
B. EHR
C. PAR
D. EOB

7. Which of the following is not necessary information on an insurance claim form?
A. Patient's gender.
B. Patient's sexual orientation.
C. Lab report.
D. Patient's ledger.

8. To complete the insurance form, the medical biller/coder needs the dates when James Roberts was unable to work. To find this information, the coder would refer to the:
A. Patient's chart.
B. Patient registration form.
C. Lab report.
D. Patient's ledger.

9. Before mailing patient statements, which of the following reports should be reviewed for delinquent accounts?
A. ERA
B. Aging Report
C. Daily report
D. EOB

10. At the end of her visit, Sarah was asked to pay $15, which is her co-share cost for today's visit through her managed care health plan. The $15 represents Sarah's:
A. Prior account balance
B. Co-payment
C. Payment toward a scheduled procedure
D. Monthly payment amount

11. Listed on an account are the father, the mother, and two minor children. One insurance policy, held by the mother, covers all four family members. Who is the guarantor on the account?
A. Mother
B. Father
C. Insurance carrier
D. Mother and Father

12. What type of agreement becomes a permanent part of the medical record?
A. Oral agreement
B. Treatment agreement
C. Hardship agreement
D. Billing agreement

13. Dependent children should be under the age of:
A. Under 26
B. Under 21
C. Under 18
D. Under 25 only if they are full-time students

14. Attempted collection of a debt by telephone cannot be made after:
A. 8 p.m.
B. 9 p.m.
C. 6 p.m.
D. 5 p.m.

15. Attempted collection of a debt by telephone cannot be made before:
A. 8 a.m.
B. 7 a.m.
C. 6 a.m.
D. 9 a.m.

16. You should not call a patient for the purpose of debt collection on a:
A. Friday
B. Monday
C. Saturday
D. Sunday

17. The administrative medical assistant must call patients whose accounts are 30 to 60 days past due. All of the following are recommended phone strategies except:
A. Call during evening hours prior to 9 p.m.
B. Ask why the bill has not been paid.
C. Discuss results of lab tests and/or procedures.
D. Use effective listening techniques.

18. Statutes of limitations for collecting debt:
A. Are mandated by the federal government.
B. May exceed 15 years.
C. Are set state to state and may vary.
D. Are not relevant to the office collection policy.

19. When a physician finds it impossible to extract payment from a patient, the account is then referred to as a \_\_\_\_\_\_\_\_\_\_ account.
A. Closed account
B. Terminated account
C. Retired account
D. Termed account

**Fill in the Blank Questions**

20. A \_\_\_\_\_\_\_\_\_\_ is attached to the patient's file when the patient registers for a visit.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

21. A \_\_\_\_\_\_\_\_\_\_ is a list of usual procedures the office performs and the corresponding charges.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

22. Charges incurred by a patient for office visits, x-rays, laboratory tests, and all adjustments and payments made by the patient or patient's insurance company are recorded in/on the:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

23. The patient's copy of the information stored in/on the patient ledger is referred to as the:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

24. The \_\_\_\_\_\_\_\_\_\_ shows the professional services rendered to the patient, the charge for each service, payments made, and the balance owed.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

25. A computerized billing program is used to generate \_\_\_\_\_\_\_\_\_\_.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

26. A daily report, called a \_\_\_\_\_\_\_\_\_\_, lists all charges, payments, and adjustments entered during that day.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

27. An accounting of patient services, charges, payments/adjustments and balance is a \_\_\_\_\_\_\_\_\_\_.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

28. A listing of medical procedures/services and usual charges is called a \_\_\_\_\_\_\_\_\_\_.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

29. The \_\_\_\_\_\_\_\_\_\_ is known as the universal insurance claim form.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

30. The \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is filled out and updated by the patient.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

31. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ are prepared on a computer and transmitted electronically to an insurance carrier for processing.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

32. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is sent through the mail in a response to a claim that was filed.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

33. An\_\_\_\_\_\_\_\_\_\_ is sent electronically in response to a claim that was filed.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

34. If the physician thinks that the reimbursement decision is incorrect, the medical office may initiate an \_\_\_\_\_\_\_\_\_\_.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

35. A claim form without errors is known as a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

36. A \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is a service bureau that collects electronic claims from many different medical practices and forwards the claims to the appropriate insurance carriers.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

37. A software program known as a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is used to check for errors on insurance claim forms before they are submitted.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

38. An insurance claim prepared on and transmitted by computer is called an \_\_\_\_\_\_\_\_\_\_.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

39. A \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ form is a universal claim form.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

40. A service that collects, corrects, and transmits insurance claims is known as a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

41. An\_\_\_\_\_ is a payment determination report sent by an insurance carrier.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

42. Payments should or should not be made to the administrative medical assistant, not the physician.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

43. Patients pay at the time of the visit by cash, check, debit card, or credit. This type of payment in known as \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

44. A \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cycle is when bills are sent once a month and are timed to reach the patient no later than the last day of the month.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

45. \_\_\_\_\_\_\_\_\_\_ is designed to avoid once-a-month peak workloads and to stabilize the cash flow.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

46. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ takes place when the cost of a procedure is changed when the need arises.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

47. A financial adjustment for PAR providers of the difference between submitted and allowable charges is known as a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

48. When a person other than the patient assumes liability or responsibility, for the charges is called \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

49. A \_\_\_\_\_\_\_\_\_\_ is an individual who is a policyholder for a patient of a medical practice.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

50. A billing method used to provide consistent cash flow is known as
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

51. A financial adjustment for PAR providers of the difference between submitted and allowable charges is known as a
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

52. An ABN is known as an \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

53. A \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is a service used to pursue payment for services.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

54. A \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is the percentage that shows the effectiveness of collection methods.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

55. When a physician finds it impossible to extract payment from a patient they may decide to terminate the physician-patient relationship. This is referred to as a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ account.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Multiple Choice Questions**

**Answers**

1.*(p. 256)* Another name for a patient encounter form is:
A. Charge slip
B. Pink slip
C. Super Bill
**D.** Both A and C answers are correct

Another name for a patient encounter form is charge slip and super bill.

2.*(p. 256)* Forms used by the medical practice should be updated \_\_\_\_\_\_\_\_\_\_ and the codes verified with the current year's diagnostic and procedural codes.
A. Every three months
B. Monthly
C. Semi-Annually
**D.** Annually

Forms used by the medical practice should be updated annually and the codes verified with the current year's diagnostic and procedural codes.

3.*(p. 256)* Select the item that does not go on the patient encounter form.
A. Patient address
B. Date of service
C. Insurance
**D.** Previous services

Previous services do not go on the patient encounter form.

4.*(p. 274)* Dr. Adams has rendered a non-covered procedure to Mrs. Johnson, who is covered by Medicare. She was not advised before the procedure that it is not covered. The medical office should:
A. Charge Mrs. Johnson for the procedure.
B. Obtain Mrs. Johnson's signature on an ABN.
**C.** Adjust the procedure charge off Mrs. Johnson's account.
D. Charge Mrs. Johnson the Medicare allowable amount for the service.

Dr. Adams has rendered a non-covered procedure to Mrs. Johnson, who is covered by Medicare. She was not advised before the procedure that it is not covered. The medical office should adjust the procedure charge off Mrs. Johnson's account.

5.*(p. 258)* An appointment was scheduled for a new patient, who asked how much the fee would be for the visit. The administrative medical assistant should:
A. Quote the highest new patient exam fee to the patient.
B. Transfer the call to the office manager.
C. Quote the mid-level new patient exam fee to the patient.
**D.** Provide an estimate of the exam but explain that the estimate is prior to other services, such as blood work.

An appointment was scheduled for a new patient, who asked how much the fee would be for the visit. The administrative medical assistant should provide an estimate of the exam but explain that the estimate is prior to other services, such as blood work.

6.*(p. 262)* Hardcopy insurance claim forms will produce which of the following?
A. ERA
B. EHR
C. PAR
**D.** EOB

Hardcopy insurance claim forms will produce an EOB.

7.*(p. 268)* Which of the following is not necessary information on an insurance claim form?
A. Patient's gender.
**B.** Patient's sexual orientation.
C. Lab report.
D. Patient's ledger.

The patient's sexual orientation is not necessary information on an insurance claim form.

8.*(p. 268)* To complete the insurance form, the medical biller/coder needs the dates when James Roberts was unable to work. To find this information, the coder would refer to the:
**A.** Patient's chart.
B. Patient registration form.
C. Lab report.
D. Patient's ledger.

To complete the insurance form, the medical biller/coder needs the dates when James Roberts was unable to work. To find this information the coder would refer to the patient's chart.

9.*(p. 272)* Before mailing patient statements, which of the following reports should be reviewed for delinquent accounts?
A. ERA
**B.** Aging Report
C. Daily report
D. EOB

Before mailing patient statements, the aging report should be reviewed for delinquent accounts.

10.*(p. 273)* At the end of her visit, Sarah was asked to pay $15, which is her co-share cost for today's visit through her managed care health plan. The $15 represents Sarah's:
A. Prior account balance
**B.** Co-payment
C. Payment toward a scheduled procedure
D. Monthly payment amount

At the end of the visit, Sarah was asked to pay $15, which is her co-share cost for today's visit through her managed care health plan. The $15 represents Sarah's co-payment.

11.*(p. 273)* Listed on an account are the father, the mother, and two minor children. One insurance policy, held by the mother, covers all four family members. Who is the guarantor on the account?
**A.** Mother
B. Father
C. Insurance carrier
D. Mother and Father

Listed on the account are the father, the mother, and two minor children. One insurance policy, held by the mother, covers all four family members. The mother is the guarantor.

12.*(p. 273)* What type of agreement becomes a permanent part of the medical record?
A. Oral agreement
B. Treatment agreement
**C.** Hardship agreement
D. Billing agreement

A hardship agreement becomes a permanent part of the medical record.

13.*(p. 274)* Dependent children should be under the age of:
**A.** Under 25
B. Under 21
C. Under 18
D. Under 25 only if they are full-time students

Dependent children should be under the age of 25.

14.*(p. 276)* Attempted collection of a debt by telephone cannot be made after:
A. 8 p.m.
**B.** 9 p.m.
C. 6 p.m.
D. 5 p.m.

Attempted collection of a debt by telephone cannot be made after 9 p.m.

15.*(p. 276)* Attempted collection of a debt by telephone cannot be made before:
**A.** 8 a.m.
B. 7 a.m.
C. 6 a.m.
D. 9 a.m.

Attempted collection of debt by telephone cannot be made before 8 a.m.

16.*(p. 276)* You should not call a patient for the purpose of debt collection on a:
A. Friday
B. Monday
C. Saturday
**D.** Sunday

You should not call a patient for the purpose of debt collection on a Sunday.

17.*(p. 276)* The administrative medical assistant must call patients whose accounts are 30 to 60 days past due. All of the following are recommended phone strategies except:
A. Call during evening hours prior to 9 p.m.
B. Ask why the bill has not been paid.
**C.** Discuss results of lab tests and/or procedures.
D. Use effective listening techniques.

The administrative medical assistant must call patients whose accounts are 30 to 60 days past due. Discussing results of lab tests and/or procedures is not allowed.

18.*(p. 278)* Statutes of limitations for collecting debt:
A. Are mandated by the federal government.
B. May exceed 15 years.
**C.** Are set state to state and may vary.
D. Are not relevant to the office collection policy.

Statutes of limitations for collecting debt are set state to state and may vary.

19.*(p. 277)* When a physician finds it impossible to extract payment from a patient, the account is then referred to as a \_\_\_\_\_\_\_\_\_\_ account.
A. Closed account
**B.** Terminated account
C. Retired account
D. Termed account

When a physician finds it impossible to extract payment from a patient, the account is then referred to as a terminated account.

**Fill in the Blank Questions**
 20.*(p. 257)* A \_\_\_\_\_\_\_\_\_\_ is attached to the patient's file when the patient registers for a visit.
**patient encounter form**

A patient encounter form is attached to the patient's file when the patient registers for a visit.

21.*(p. 258)* A \_\_\_\_\_\_\_\_\_\_ is a list of usual procedures the office performs and the corresponding charges.
**fee schedule**

A fee schedule is a list of usual procedures the office performs and the corresponding charges.

22.*(p. 258)* Charges incurred by a patient for office visits, x-rays, laboratory tests, and all adjustments and payments made by the patient or patient's insurance company are recorded in/on the:
**patient ledger**

Charges incurred by a patient for office visits, x-rays, laboratory tests, and all adjustments and payments made by the patient or patient's insurance company are recorded in/on the patient ledger.

23.*(p. 258)* The patient's copy of the information stored in/on the patient ledger is referred to as the:
**patient statement**

The patient's copy of the information stored in/on the patient ledger is referred to as the patient statement.

24.*(p. 258)* The \_\_\_\_\_\_\_\_\_\_ shows the professional services rendered to the patient, the charge for each service, payments made, and the balance owed.
**patient statement**

The patient statement shows the professional services rendered to the patient, the charge for each service, payments made, and the balance owed.

25.*(p. 259)* A computerized billing program is used to generate \_\_\_\_\_\_\_\_\_\_.
**patient statements**

A computerized billing program is used to generate patient statements.

26.*(p. 260)* A daily report, called a \_\_\_\_\_\_\_\_\_\_, lists all charges, payments, and adjustments entered during that day.
**day-sheet**

A daily report, called a day-sheet, lists all charges, payments, and adjustments entered during the day.

27.*(p. 260)* An accounting of patient services, charges, payments/adjustments and balance is a \_\_\_\_\_\_\_\_\_\_.
**Patient statement**

An accounting of patient's services, charges, payments/adjustments and balance is a patient statement.

28.*(p. 260)* A listing of medical procedures/services and usual charges is called a \_\_\_\_\_\_\_\_\_\_.
**fee schedule**

A listing of medical procedures/services is called a fee schedule.

29.*(p. 261)* The \_\_\_\_\_\_\_\_\_\_ is known as the universal insurance claim form.
**CMS-1500**

The CMS-1500 is known as the universal insurance claim form.

30.*(p. 261)* The \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is filled out and updated by the patient.
**Patient information form**

The patient information form is filled out and updated by the patient.

31.*(p. 262)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ are prepared on a computer and transmitted electronically to an insurance carrier for processing.
**Electronic claims**

Electronic claims are prepared on a computer and transmitted electronically to an insurance carrier for processing.

32.*(p. 262)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is sent through the mail in a response to a claim that was filed.
**Explanation of benefits**

Explanation of benefits is sent through the mail in a response to a claim that was filed.

33.*(p. 262)* An\_\_\_\_\_\_\_\_\_\_ is sent electronically in response to a claim that was filed.
**Electronic Remittance Advice**

An electronic remittance advice is sent electronically to a claim that was filed.

34.*(p. 264)* If the physician thinks that the reimbursement decision is incorrect, the medical office may initiate an \_\_\_\_\_\_\_\_\_\_.
**Appeal**

If the physician thinks that the reimbursement decision is incorrect, the medical office may initiate an appeal.

35.*(p. 269)* A claim form without errors is known as a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
**Clean Claim**

A claim form without errors is known as a clean claim.

36.*(p. 269)* A \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is a service bureau that collects electronic claims from many different medical practices and forwards the claims to the appropriate insurance carriers.
**Clearinghouse**

A clearinghouse is a service bureau that collects electronic claims from many different medical practices and forwards the claims to the appropriate insurance carriers.

37.*(p. 269)* A software program known as a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is used to check for errors on insurance claim forms before they are submitted.
**Scrubber program**

A software program known as a scrubber program are used to check for errors on insurance claim forms before they are submitted.

38.*(p. 269)* An insurance claim prepared on and transmitted by computer is called an \_\_\_\_\_\_\_\_\_\_.
**Electronic claim**

An insurance claim prepared on and transmitted by computer is called an electronic claim.

39.*(p. 269)* A \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ form is a universal claim form.
**CMS-1500**

A CMS-1500 form is a universal claim form.

40.*(p. 269)* A service that collects, corrects, and transmits insurance claims is known as a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
**Clearinghouse**

A clearinghouse is a service that collects, corrects, and transmits insurance claims.

41.*(p. 269)* An\_\_\_\_\_ is a payment determination report sent by an insurance carrier.
**ERA**

An ERA is a payment determination report sent by an insurance carrier.

42.*(p. 271)* Payments should or should not be made to the administrative medical assistant, not the physician.
**Should**

Payments should be made to the administrative medical assistant, not the physician.

43.*(p. 271)* Patients pay at the time of the visit by cash, check, debit card, or credit. This type of payment in known as \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
**Collection at the time of services**

Patients pay at the time of the visit by cash, check, debit card, or credit. This type of payment is known as collection at the time of services.

44.*(p. 271)* A \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cycle is when bills are sent once a month and are timed to reach the patient no later than the last day of the month.
**Monthly billing**

A monthly billing cycle is when bills are sent once a month and are timed to reach the patient no later than the last day of the month.

45.*(p. 272)* \_\_\_\_\_\_\_\_\_\_ is designed to avoid once-a-month peak workloads and to stabilize the cash flow.
**Cycle billing**

Cycle billing is designed to avoid once-a-month peak workloads and to stabilize the cash flow.

46.*(p. 272)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ takes place when the cost of a procedure is changed when the need arises.
**Fee adjustment**

Fee adjustment takes place when the cost of a procedure is changed when the need arises.

47.*(p. 272)* A financial adjustment for PAR providers of the difference between submitted and allowable charges is known as a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
**Write-off**

A financial adjustment for PAR providers of the difference between submitted and allowable charges is known as a write-off.

48.*(p. 274)* When a person other than the patient assumes liability or responsibility, for the charges is called \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
**Third-party liability**

When a person other than the patient assumes liability or responsibility, for the charges is called third-party liability.

49.*(p. 274)* A \_\_\_\_\_\_\_\_\_\_ is an individual who is a policyholder for a patient of a medical practice.
**Guarantor**

A guarantor is an individual who is a policyholder for a patient of a medical practice.

50.*(p. 274)* A billing method used to provide consistent cash flow is known as
**Cycle billing**

A billing method used to provide consistent cash flow is known as cycle billing.

51.*(p. 274)* A financial adjustment for PAR providers of the difference between submitted and allowable charges is known as a
**Write-off**

A financial adjustment for PAR providers of the difference between submitted and allowable charges is known as a write-off.

52.*(p. 274)* An ABN is known as an \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
**Advance Beneficiary Notice**

An ABN is known as an advance beneficiary notice.

53.*(p. 276)* A \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is a service used to pursue payment for services.
**Collection agency**

A collection agency is a service used to pursue payment for services.

54.*(p. 276)* A \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is the percentage that shows the effectiveness of collection methods.
**Collection Ratio**

A collection ratio is the percentage that shows the effectiveness of collection methods.

55.*(p. 277)* When a physician finds it impossible to extract payment from a patient they may decide to terminate the physician-patient relationship. This is referred to as a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ account.
**Terminated**

When a physician finds it impossible to extract payment from a patient they may decide to terminate the physician-patient relationship. This is referred to as a terminated account.