Assignment Pack

Medical Claims and Billing Specialist

Pack 1

This Assignment Pack contains the Quizzes you will need to complete your course. The Lessons will tell you when to complete each Quiz. If you have not yet accessed your Lessons, you can download your Electronic Lesson Book or order a printed copy from the Student Site, www.uscareerinstitute.edu. If you have questions, please contact Student Services at 1-800-347-7899.
Instructions for Quizzes

1. Be sure you’ve mastered the Lessons and Practice Exercises that this Quiz covers.
2. Mark your answers on the Quiz, and make sure to check your answers by reviewing the Lessons.
3. When you’re finished, decide how you will submit your answers and then follow the correct instructions below. You may only submit your answers for a Quiz once. Important: When submitting your Quiz, be sure to include your name, address, student ID number and course code. Incomplete information may result in your Quiz not being processed.

Scanner Quiz Instructions

For a Quiz that contains only multiple-choice questions, please select the method of submission:

- **Online**: Submit your answers online and receive your grade immediately by submitting them to the student site, www.uscareerinstitute.edu.
- **Phone**: Call the Quiz Line at 1-877-599-5857 and give your answers over the phone to receive your grade immediately.
- **Mail or Fax**: Scanner Answer Sheets and addressed envelopes are included with each print Assignment Pack. Transfer your Quiz answers to the Scanner Answer Sheet, using only blue or black ink. Mail your Scanner Answer Sheet using the enclosed envelope, or fax the form to 1-877-599-5863.

Instructor-Graded Quiz Instructions

For the quickest response to instructor-graded Quizzes, simply e-mail your completed Quiz as an attachment to your instructor at assignments@uscareerinstitute.edu. In most cases, you will receive the graded Quiz back via e-mail within three business days.

To ensure your instructor can grade your Quiz electronically, please create documents using one of the following preferred software programs: Microsoft® Word, Microsoft® Works or WordPerfect®. Make sure to include your **name**, **student ID**, **course code** and **Quiz number** in the subject line of your e-mail. Include your address in the e-mail. Finally, please note that these instructions only apply to handwritten Quizzes. Thank you and good luck!

For a Quiz that contains Instructor-graded questions, please select the method of submission:

- **Online**: Submit your answers online for an instructor to review and grade by submitting them to the student site, www.uscareerinstitute.edu.
- **Mail or Fax**: Scanner Answer Sheets and addressed envelopes are included with each print Assignment Pack. Transfer your Quiz answers to the Answer Sheet, using only blue or black ink. Mail your Cover Sheet and Answer Sheet using the enclosed envelope, or fax the form to 1-877-599-5863.

After you have submitted your Quiz answers, you may begin the next lesson. You do not need to wait for your Quiz results to move on to the next lesson!
Medical Claims and Billing Specialist
Quiz 1: Welcome to the Exciting World of Medicine and Medical Claims

This is a Scanner Quiz that should be submitted according to the instructions at the beginning of this pack.

For questions 1 through 15, select the best answer from the choices provided. Each item in this quiz is worth 6.67 points.

1. A ____ is a document that is generated when a patient receives medical care.
   a. statement of medical transaction
   b. medical bill
   c. generated user interface document
   d. patient-doctor relationship account

2. The first step in the lifecycle of a medical bill occurs when the _____.
   a. patient fills out a questionnaire at the doctor’s office, clinic or hospital
   b. patient makes a follow-up appointment
   c. initial payment is received
   d. account is fully paid

3. Typically, the questionnaire a patient fills out at the medical facility contains _____.
   a. nothing of interest to a medical claims specialist
   b. the doctor's home telephone number
   c. questions about the patient’s medical history and insurance coverage
   d. a privacy policy

4. Some doctors’ offices use a(n) _____, which is a form that contains the most common procedures performed by that doctor.
   a. account-easing document
   b. easy-accounting bill
   c. encounter form
   d. claim form

5. When an insurance company pays for medical services, it ____ the appropriate party (either the insured or the medical office).
   a. gerrymanders
   b. processes
   c. collects from
   d. reimburses
6. If an insurance company pays 80 percent of a claim of $100, the patient is responsible for _____ percent of the bill.
   a. 20
   b. 10
   c. 80
   d. 100

7. As a medical claims and billing specialist, it is your responsibility to _____ for the doctors you work for.
   a. schedule appointments for
   b. examine patients
   c. submit insurance claims
   d. determine each patient's diagnosis and appropriate treatment

8. Two essential qualities of a good medical claims specialist are _____.
   a. tenacity and toughness
   b. accuracy and thoroughness
   c. understanding and free-spiritedness
   d. being argumentative and unlikable

9. The insurance company that is billed after the primary carrier has paid is called the _____ carrier.
   a. back-up
   b. held-back
   c. second-hand
   d. secondary

10. The most commonly used insurance form is called the _____.
   a. CMS-1500
   b. CMS-1000
   c. Common Carrier Insurance Form (CCIF)
   d. Primary Carrier Claim Form (PCCF)

11. A medical bill might be outstanding because the _____.
    a. clinic isn't waiting for the insurance payment
    b. patient paid the balance because he does not have insurance
    c. insurance company only pays quarterly
    d. insurance company has paid, but there is still a balance due for the patient to pay
12. Paying someone for services already performed is _____.
   a. claims processing
   b. completing an encounter
   c. reimbursement
   d. always an insurance company’s responsibility

13. After the primary carrier has paid its share of the bill, the claims specialist should then _____.
   a. close the file as “uncollectible”
   b. re-bill the primary carrier for the remaining amount
   c. bill the tertiary carrier
   d. bill the secondary carrier, if there is one, or the patient if there is not

14. The medical claims specialist uses _____ to gather patient information.
   a. an informal survey
   b. an insurance salesperson
   c. the encounter form or other medical bill
   d. the doctor

15. Essentially, confidential means _____.
   a. secret
   b. you can release the information to anyone
   c. you can tell your neighbor about it
   d. information
Quiz 2: The Third-party Payer: How Insurance Works

This is a Scanner Quiz that should be submitted according to the instructions at the beginning of this pack.

Select the best single answer for each of the following items. Each item in this quiz is worth 5 points.

1. When an insurance carrier pays for medical treatment based on a policy, it is paying _____.
   a. premiums
   b. a co-payment
   c. benefits
   d. HMOs

2. The _____ is a document that explains how much the insurance company paid on a claim.
   a. explanation of benefits
   b. insurance statement
   c. insurance policy
   d. PPO

For items 3 through 6, match the insurance program with its description.

3. _____ Medicare  a. program that covers veterans with permanent, service-related disabilities and their families
4. _____ Medicaid  b. a state-sponsored insurance program for low-income people
5. _____ TRICARE  c. a federal health care plan covering people age 65 and older and people with disabilities
6. _____ CHAMPVA  d. provides medical coverage for active duty and retired members of the various uniformed government services and their families

For questions 7 through 11, select the best answer from the choices provided.

7. A state-run program that pays the medical bills for people with job-related injuries or illnesses is called _____.
   a. PPO
   b. Medicaid
   c. workers’ compensation
   d. managed care
8. The traditional insurance company paid out benefits based on a(n) _____ concept.
   a. managed care  
   b. HMO  
   c. PPO  
   d. fee-for-service

9. Managed care was born in the 1980s _____.
   a. because doctors wanted more authority over fees  
   b. in response to rising healthcare costs  
   c. in response to doctors' wishes for better insurance service  
   d. because employers wanted more comprehensive and expensive insurance policies

10. HMO stands for _____.
    a. Hired Medical Organization  
    b. Hired Medical Officer  
    c. Health Maintenance Organization  
    d. Health Maintenance Operation

11. PPO stands for _____.
    a. Preferred Provider Organization  
    b. Policy Protection Operation  
    c. Premium Protection Operation  
    d. Preferred Premium Operation

For items 12 through 15, match the term with its definition.

12. _____ Provider
    a. An amount of money an individual must pay before insurance benefits kick in

13. _____ Deductible
    b. Refers to price guidelines used by insurance carriers for different procedures

14. _____ Co-payment
    c. A flat amount of money paid by the patient every time a medical service is performed

15. _____ Reasonable and customary
    d. A person or organization that provides medical services
Using the following explanation of benefits example, answer questions 16 through 20.

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>Dr. Liv Nogood</th>
<th>Dates of Service:</th>
<th>05/29/20XX</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Service</strong></td>
<td><strong>Submitted Charge</strong></td>
<td><strong>Disallowed Charge</strong></td>
<td><strong>Allowable Charge</strong></td>
</tr>
<tr>
<td>Lab</td>
<td>29.00</td>
<td>7.00</td>
<td>22.00</td>
</tr>
<tr>
<td>Lab</td>
<td>55.00</td>
<td>18.00</td>
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</tr>
<tr>
<td>Lab</td>
<td>86.00</td>
<td>16.00</td>
<td>70.00</td>
</tr>
<tr>
<td>Totals</td>
<td>170.00</td>
<td>41.00</td>
<td>129.00</td>
</tr>
</tbody>
</table>

16. How much does the insured owe (not including the co-payment, which has already been paid)? In this case, the patient is not responsible for the disallowed charge.
   a. $0.00
   b. $61.00
   c. $129.00
   d. $20.00

17. What is the maximum amount the insurance carrier will cover for the services?
   a. $170.00
   b. $129.00
   c. $109.00
   d. $41.00

18. What is the amount that exceeds the reasonable and customary price scale?
   a. $129.00
   b. $109.00
   c. $41.00
   d. $0.00

19. According to the EOB, this patient’s deductible _____.
   a. has not been met
   b. has been met
   c. is $20.00
   d. is $250.00

20. The co-payment is ____ and is paid by the _____.
   a. $10.00/doctor’s office
   b. $15.00/patient
   c. $20.00/carrier
   d. $20.00/patient
Quiz 3: Handling Claims

This is a Scanner Quiz that should be submitted according to the instructions at the beginning of this pack.

Select the best single answer for each of the following items. Each item in this quiz is worth 5 points.

1. If preauthorization is required, but the insurance company is not notified, the insurance company _____.
   a. bills the doctor for the cost of the extra paperwork involved
   b. might reduce reimbursement
   c. pays more
   d. any of the above

2. In order to review hospitalizations, surgeries and to reduce fraud, the insurance company _____.
   a. can require preauthorization
   b. might contract with a third-party oversight company
   c. increases benefits for fraudulent claims
   d. both a and b are correct

3. If an insurance company authorizes a hospital stay of five days and the patient stays seven days (not due to any medical necessity), then the _____.
   a. patient must pay for the extra two days
   b. hospital allows the patient to stay for free for the extra two days
   c. insurance carrier pays for the extra two days
   d. insurance agent must pay a penalty

4. Numbers based on the diagnosis made and procedures performed are called _____.
   a. codes
   b. checks
   c. HMOs
   d. terms

5. The diagnosis code is entered in field _____ of the CMS-1500 form.
   a. 31
   b. 1
   c. 21
   d. 24A
6. Codes that identify the physician’s opinion about what’s wrong with a patient are called ______ codes.
   a. procedure
   b. diagnosis
   c. HCPCS
   d. Medicare

7. ICD stands for ______.
   a. International Coding Decimals
   b. International Coding Disorders
   c. International Classification of Diseases
   d. Internal Classification of Disorders

8. If a patient is suffering from more than one symptom, the doctor will determine a ______, usually the main cause of the symptoms or the main health problem.
   a. primary diagnosis
   b. concurrent condition
   c. concurrent diagnosis
   d. primary prognosis

9. HCPCS stands for ______.
   a. Honorary Coding Procedures Common System
   b. Healthcare Common Procedure Coding System
   c. Health Care Primary Coding System
   d. Hired Care Primary Coding System

10. CPT stands for ______.
    a. Colorado Procedure Tests
    b. Corporate Procedure Terminology
    c. Current Primary Tests

For items 11 through 13, match the coding term with its definition or description.

11. _____ ICD a. codes produced annually by the American Medical Association
12. _____ CPT b. pronounced “Hick-Picks”
13. _____ HCPCS c. diagnosis codes
Select the best single answer for each of the following items.

14. **When you trace an insurance claim, you should send the _____ to the insurance company.**
   a. name of the insured
   b. date of service
   c. procedures performed
   d. all of the above

15. **If an insurance company denies a claim, the _____ .**
   a. decision is final
   b. doctor can appeal the decision
   c. doctor can request a peer review
   d. both b and c are correct

For questions 16 and 17, use the following form.

16. An encounter form shows a patient was diagnosed with intermediate coronary syndrome. In which field will you enter the diagnosis code on the CMS-1500 claim form?
   a. 19
   b. 21
   c. 24D
   d. 24E
17. A patient has a biopsy done on her lip. In which field will you enter the procedure code on the CMS-1500 claim form?
   a. 19
   b. 24C
   c. 24D
   d. 24E

Select the best single answer for each of the following items.

18. As a claims specialist, you discover that Juanita Rodriguez’s insurance company has not reimbursed the doctor’s office for her bill, and 37 days have elapsed since you submitted the claim. You should _____ the insurance company.
   a. write a letter to
   b. call
   c. submit a second claim to
   d. any of the above

19. Doctor Feelgood performs laboratory tests for his patient, Will Siesta. The claims specialist will code these tests as _____ codes.
   a. modifier
   b. diagnosis
   c. procedure
   d. CMS

20. Doctor Obie charts that her patient, Sarah Gooding, has a sprained ankle. The claims specialist will code this as a _____.
   a. modifier
   b. diagnosis
   c. procedure
   d. CMS
Quiz 4: Private Insurance and Managed Care Programs

This is an Instructor-graded Quiz that should be submitted according to the instructions at the beginning of this pack.

For questions 1 through 10, select the correct word or phrase that best completes each sentence. You’ll use all the terms. Each item in this quiz is worth 4 points.

- customary maximum
- fight rising healthcare costs
- PPOs
- preferred provider organizations
- insurance policy
- HMO
- reduced or denied
- fixed fee schedule
- primary physician
- threshold limit

1. A(n) _____ describes insurance benefits and coverage information.

2. _____ is the maximum fee allowed for a specific medical service or procedure.

3. _____ is the fee charged by most doctors in the community.

4. Managed care started in order to help _____.

5. The most popular choice in managed care is the _____.

6. If an HMO patient is treated by a nonparticipating physician, the patient’s insurance benefits are _____.

7. PPO stands for _____.

8. The _____ is the doctor in charge of a particular patient in an HMO.

9. One difference between HMOs and PPOs is that members of _____ can choose their own doctors and treatment facilities and still receive benefits.

10. The total amount of bills at which point the co-payment is dropped is called the _____.
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For questions 11 through 21, select the correct word or phrase that best completes each sentence. You’ll use all the terms.

write a letter  physician provider  advance approval for
groups  certain procedures
EOB  capitation arrangement  point of service plans
appeal the decision  peer review organizations  Medicare bill of 2003
reduced  number of visits to a specialist

11. _____ strive to combine the best elements of both HMOs and PPOs.
12. _____ are managed care programs that are owned by the physicians.
13. If a patient fails to get proper preauthorization, the patient’s benefits will be _____.
14. _____ examine and ensure quality health care in managed care situations.
15. Preauthorization is the _____.
16. When a physician’s reimbursement is based on how many patients the physician sees instead of the services performed, the physician is participating in a(n) _____.
17. Visitation limits refers to the _____ a patient may make.
18. When you see the term disallowed on a document, you should carefully review the _____ to make sure the denial is correct.
19. If you believe the EOB is incorrect, you should _____.
20. If the managed care program mistakenly denies coverage, you may have to _____ of appeal.
21. The _____ was designed to help individuals to save for future medical expenses on a tax-free basis.
For questions 22 through 25, match the term to the correct definition.

22. _____ PPG  
   a. a group of physicians and hospitals who give plan members discounted health care for plan participants

23. _____ HMO  
   b. prepaid health plan in which individuals receive medical services from participating physicians

24. _____ PPO  
   c. members choose their own medical care providers, with care from a participating physician or facility resulting in increased benefits

25. _____ POS  
   d. groups of physicians who negotiate contracts with employers, insurance companies and other entities in order to provide healthcare coverage
Medical Claims and Billing Specialist
Medical Claims and Billing Specialist
Quiz 4

1. Fill in your **student ID** and your **course code** below.

<table>
<thead>
<tr>
<th>STUDENT ID NUMBER</th>
<th>COURSE CODE</th>
</tr>
</thead>
</table>

2. Be sure your **name** and **address** are filled in below.

3. **Transfer your answers** to this cover sheet.

<table>
<thead>
<tr>
<th>NAME</th>
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</thead>
<tbody>
<tr>
<td>ADDRESS</td>
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<td>CITY</td>
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</table>

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**This Space for Instructor Use**

Grade: ___________

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1. _____________________________________________________________________________
2. _____________________________________________________________________________
3. _____________________________________________________________________________
4. _____________________________________________________________________________
5. _____________________________________________________________________________
6. _____________________________________________________________________________
7. _____________________________________________________________________________
8. _____________________________________________________________________________
Quiz 5: Medicaid and Medicare

This is a Scanner Quiz that should be submitted according to the instructions at the beginning of this pack.

For questions 1 through 20, select the best answer from the choices provided. Each item in this quiz is worth 4 points.

1. The main purpose of CMS is to _____.
   a. purchase healthcare services for the Medicare and Medicaid programs
   b. administer healthcare benefits to its beneficiaries
   c. govern the Department of Health and Human Services
   d. all of the above

2. Low-income families with children and infants born to Medicaid-eligible women are examples of _____ recipients.
   a. Medicare
   b. medically needy
   c. categorically needy
   d. Social Security Supplemental Income (SSI)

3. Medically needy Medicaid recipients _____.
   a. include SSI recipients
   b. have too much income to qualify for the categorically needy groups
   c. must have preauthorization for every visit and service
   d. include workers of any age who are disabled

4. Children whose families receive TANF may benefit from Medicaid through a program called _____ that provides preventive services and early detection and treatment.
   a. EPSDT (Early and Periodic Screening, Diagnosis and Treatment)
   b. HS Head Start
   c. Early Start
   d. EPFP (Early and Periodic Family Planning)

5. The ABN form informs the patient of the procedure and why it is _____.
   a. covered
   b. covered but the patient is responsible for the payment
   c. not covered
   d. none of the above
6. _____ is the review of proposed treatment by Medicaid to determine whether or not the treatment is appropriate.
   a. Reciprocity
   b. An appeal
   c. DHHS review
   d. Preauthorization

7. The process of a home state Medicaid program paying a claim for medical services that occur in another state is called _____.
   a. preauthorization
   b. an appeal
   c. reciprocity
   d. transference

8. The _____ explains the actions Medicaid has taken on a patient's claims.
   a. explanation of medical benefits
   b. explanation of benefits
   c. claims review
   d. Medicaid claim summary

9. If a patient is eligible for Medicaid and also has additional health insurance, Medicaid becomes the _____ carrier.
   a. primary
   b. secondary
   c. tertiary
   d. Answer could be any of the above; every claim is unique.

10. Medicare is administered by the _____ government and funded by the _____ government.
    a. federal, federal
    b. federal, state
    c. state, federal
    d. state, local

11. Medicare Part A pays for _____, and Part B pays for _____.
    a. physician services, hospital services
    b. medical expenses, hospital services
    c. clinic services, pharmaceuticals
    d. hospital services, medical expenses
12. Medicare Part A is financed by _____.
   a. fiscal agents
   b. the federal government
   c. Social Security payroll withholding tax paid by workers and their employers
   d. monthly premiums paid by enrollees

13. Medicare Part B is financed by _____.
   a. fiscal agents
   b. the federal government
   c. Social Security payroll withholding tax paid by workers and their employers
   d. monthly premiums paid by enrollees

14. Medicare preventive services include _____.
   a. mammography
   b. glaucoma screening
   c. nutritional therapy
   d. all of the above

15. The Medicare term _____ charge refers to whichever charge is the lowest of the following: customary charge, prevailing charge and actual charge.
   a. approved
   b. intermediary
   c. case-by-case
   d. acceptance

16. Because Medicaid programs are run by each individual state, the requirements for billing _____.
   a. vary from state to state
   b. are the same for every state
   c. are dictated by the federal government
   d. are submitted to a federal agency and a state agency

17. Medicare fraud is reported to the _____.
   a. Office of Inspection of fraud
   b. Office of Inspector General
   c. Office of Medicare fraud
   d. Official Inspector General
18. _____ insurance can be purchased to supplement Medicare insurance.
   a. Medi-Medi
   b. Medicaid
   c. Medicare Part C
   d. Medigap

19. When a patient is eligible for both Medicare and Medicaid, you should submit claims to _____ first.
   a. Medicare
   b. Medicaid
   c. the primary insurance carrier
   d. Medigap

20. An EOMB is a(n) _____.
   a. CMS policy that ensures health safety and accountability
   b. explanation of Medicaid benefits
   c. explanation of Medicare benefits
   d. statement of explanation for Medicare Part C

For questions 21 through 25, match the group of people with the healthcare program for which it would be eligible.

21. _____ Those who qualify for TANF
   a. Medicare
   b. Medicaid

22. _____ Disabled workers

23. _____ Those who cannot afford care

24. _____ Children and adults with end-stage renal disease

25. _____ Those who are blind; income above federal poverty level
Quiz 6: Military Insurance, Workers’ Compensation and COBRA

This is a Scanner Quiz that should be submitted according to the instructions at the beginning of this pack.

For questions 1 through 17, select the best answer from the choices provided. Each item in this quiz is worth 5 points.

1. _____ provides healthcare options for families of active-duty service members.
   a. CHAMPVA
   b. TRICARE
   c. Blue Cross and Blue Shield
   d. The Government Employees’ Union

2. The family members of uniformed service members are called _____.
   a. sponsors
   b. beneficiaries
   c. reciprocity recipients
   d. fiscal agents

3. DEERS requires the _____ to register the beneficiaries.
   a. family member
   b. doctor
   c. government
   d. military sponsor

4. _____ was developed in 1966 to control the rising costs of healthcare coverage and to standardize healthcare benefits. It is now referred to as TRICARE Standard.
   a. CHAMPVA
   b. CHAMPUS
   c. CHAMPGOV
   d. Workers’ comp

5. The TRICARE program that gets a discount on services and has a reduced cost-sharing fee is TRICARE _____.
   a. Extra
   b. Prime
   c. Standard
   d. Inclusive
6. TRICARE _____ is the TRICARE program most like an HMO.
   a. Extra
   b. Standard
   c. Inclusive
   d. Prime

7. The program established to provide health care for the families of veterans with service-connected disabilities is _____.
   a. CHAMPUS
   b. CHAMPVA
   c. TRICARE Prime
   d. TRICARE Extra

8. CHAMPVA was established in _____.
   a. 1973
   b. 1994
   c. 1947
   d. 1924

9. _____ is the Department of Defense’s regionally managed care program.
   a. CHAMPVA
   b. DEERS
   c. TRICARE
   d. S.A.F.E.

10. An organization that contracts with the government to handle TRICARE and CHAMPVA claims is called a _____.
    a. claims intermediary
    b. fiscal intermediary
    c. fiscal advisor
    d. benefits advisor

11. If a patient is seeking treatment at a nonmilitary facility, TRICARE and CHAMPVA may require a ____ from the military hospital.
    a. co-payment
    b. nonavailability statement (NAS)
    c. military waiver statement (MWS)
    d. copy of the patient’s records
12. The Federal Coal Mine Health and Safety Act is often referred to as the _____.
   a. American Lung Association Act
   b. Miner’s Union Act
   c. Black Lung Benefits Act
   d. TRICARE Black Lung Act

13. **FECA** provides benefits for _____ injuries and _____ illnesses.
   a. minor/terminal
   b. similar/brief
   c. related/occasional
   d. traumatic/occupational

14. Workers’ compensation is a _____ carrier for job-related injuries.
   a. primary
   b. tertiary
   c. secondary
   d. disability

15. Employers are required to complete Form _____ to authorize the first 60 days of treatment for a FECA claim.
   a. CA-14
   b. CA-16
   c. CMS-1450
   d. CMS-1500

16. For a person to receive disability benefits, the disability must be defined as a _____ disability.
   a. permanent
   b. legal
   c. medical
   d. conditional

17. For the Social Security Disability program, a legal disability _____.
   a. is the same as a medical disability
   b. is more than 51 percent disabling, causing the worker to experience minor difficulty in performing certain industrial jobs
   c. does not prevent the worker from working
   d. prevents the worker from doing any work
For questions 18 through 20, match the definition with the corresponding workers' compensation terms.

18. _____ Provides the initial information regarding the on-the-job injury  
   a. First Report of Injury
   b. Indemnity
   c. Progress report

19. _____ Provides the compensation carrier with the progress of the patient

20. _____ Compensation for a loss
Quiz 7: Medical Terminology—Word Parts

This is a Scanner Quiz that should be submitted according to the instructions at the beginning of this pack.

Select the best single answer for each of the following items. Remember, you may use your flashcards to answer these questions. Each item on this quiz is worth 5 points.

1. **Words are often made up of smaller _____.**
   a. prefixes
   b. word parts
   c. medical terms
   d. sentences

2. **The foundation of a word is called a _____.**
   a. root word
   b. word’s base
   c. suffix
   d. prefix

3. **Word parts can be called the _____ of words.**
   a. ladders
   b. building blocks
   c. root words
   d. grammar

4. **A word part that is attached to the end of a word is a _____.**
   a. box car
   b. prefix
   c. combining vowel
   d. suffix

5. **A prefix is found at the _____ of a word.**
   a. end
   b. middle
   c. beginning
   d. none of the above
6. In many medical terms, the _____ joins a root word to a suffix.
   a. prefix
   b. apostrophe
   c. locomotive
   d. combining vowel

7. If driver means a person who drives, what would swimmer mean?
   a. to swim again
   b. to swim past
   c. a person who swims
   d. a person who drives and swims

8. Which of the following is a compound word?
   a. bookshelf
   b. love
   c. booklet
   d. trust

9. A suffix is attached to the word part called the _____.
   a. end
   b. root word
   c. prefix
   d. adjective

10. A word that is made up of two or more root words is called a _____.
    a. combining vowel
    b. compound word
    c. double root
    d. none of the above

11. In the term neo/nat/o/log/ist, the word part nat/ is a _____.
    a. suffix
    b. prefix
    c. combining vowel
    d. root word
12. In the term neo/nat/o/log/ist, the word part neo/ is a _____.
   a. prefix
   b. root word
   c. combining vowel
   d. suffix

13. In the term dermat/o/logy, the word part /o/ is called a _____.
   a. suffix
   b. prefix
   c. combining vowel
   d. root word

14. If reread means to read again, what does review mean?
   a. to view again
   b. to view backwards
   c. to view sometime in the past
   d. to view and read together

15. _____ means to play sometime in the past.
   a. Replay
   b. Player
   c. Played
   d. Will play

For items 16 through 20, select the correct root word for each meaning.

16. skull
   a. criani/o
   b. crani/o
   c. neur/o
   d. cardi/o

17. liver
   a. lith/o
   b. hepat/o
   c. duct/o
   d. hist/o
18. **kidney**
   a. ren/o
   b. tens/o
   c. col/o
   d. enter/o

19. **clot**
   a. therm/o
   b. muc/o
   c. thromb/o
   d. myel/o

20. **stomach**
   a. enter/o
   b. hydr/o
   c. arthr/o
   d. gastr/o