Understanding Other Coverage Codes (OCC)

Other Coverage Codes are used to communicate claim information to the next downstream payer. For example, if you file a claim to a primary insurance and then file to the secondary payer (next downstream payer), the Other Coverage Code communicates how the previous payer responded to the claim.

Other Coverage Code definitions:

0 = Not specified by patient

This code is used to document that the pharmacy can't verify the availability of additional insurance coverage beyond the primary insurance. An OCC of 0 can only be used on the patient's primary insurance.

1 = No other coverage

This code is used to document that the pharmacy has verified that there is no additional insurance coverage available for this patient. An OCC of 1 can only be used on the patient's primary insurance.

2 = Other coverage exists – payment collected

This code lets the downstream payer know that the previous insurance was billed and replied with an accepted response and returned dollar amounts that represent payment to the pharmacy.

3 = Other coverage billed – claim not covered

This code lets the downstream payer know that the previous insurance was billed and replied with a rejected response. The reject codes from the previous payer will be sent to the downstream payer.

4 = Other coverage exists – payment not collected

This code lets the downstream payer know that the previous insurance was billed and replied with an accepted response but did NOT return dollar amounts that represent payment to the pharmacy. For example, the previous payer billed was a 100% copay plan.

8 = Claim is billing for patient financial responsibility only

This code lets the downstream payer know that the previous insurance was billed and replied with an accepted response. This code is used if the downstream payer requests the patient financial responsibility (previously known as copay) only.