DECEMBER 2024

BlueAlert℠

Mission driven FOR 75 Years

A monthly newsletter for our provider community, featuring important updates and reminders about our company's policies and procedures. All information is broken out by line of business.

BlueCross BlueShield of Tennessee, Inc.

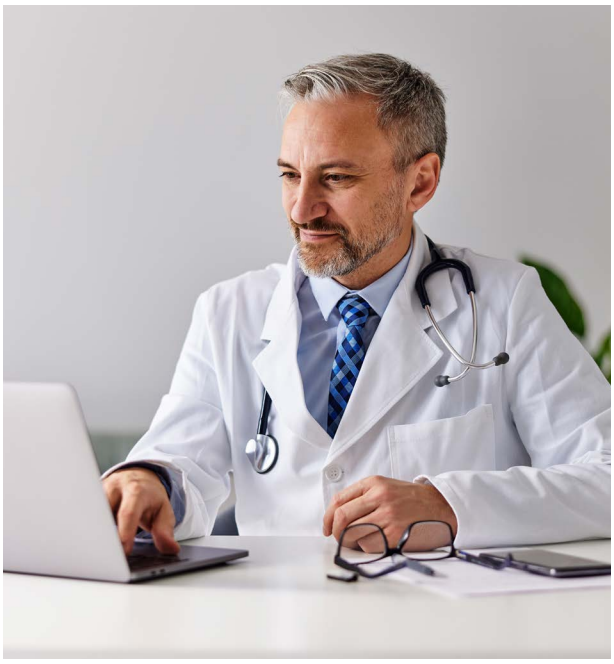
This information applies to all lines of business unless stated otherwise.

INSIDE THIS ISSUE

Providers to Submit EFT, ERA and Enrollment Requests Through Change Healthcare Starting Dec. 2

Beginning Dec. 2, we'll no longer accept paper transactions, including Electronic Funds Transfer (EFT), Electronic Remittance Advice (ERA) or enrollment requests. All new providers must submit their EFT requests through Change Healthcare **before** submitting enrollment requests. Once the EFT application is approved through Change Healthcare, you can submit your enrollment request by logging in to Availity® and selecting the **Provider Enrollment, Updates and Changes** tile in our **Payer Spaces**. Next, you'll see **Helpful Hints and Pre-Requisites for Enrollment** with instructions.

If you receive a message requesting review and completion of the Change Healthcare application (Error 1226), please use this **link** to access provider enrollment.



New Paper Check Process for Providers Enrolled for Electronic Remits

To reduce paper and streamline processes, we've changed the way we manage payment for providers who've asked for electronic 835 remits but want to receive paper checks. Starting **Nov. 1, 2024**, these providers have been receiving their checks by mail – and are no longer receiving the paper remits that were attached to the checks. As always, these providers can access their remittance advice online through Availity at **Availity.com**. **Please note, this won't affect providers enrolled for paper remits and checks at this time.** They'll continue to receive both items together in the mail.

If you have questions, please call our Provider Service line at **(423) 924-7141** and follow the prompts for general inquires. You may also reference the Provider Administration Manual for more details about registering with Availity or contact our eBusiness Service team at **(423) 535-5717 (option 2)**.

Change of Ownership or Control Process

A change of ownership or control (CHOW) is a business transaction where the ownership or controlling interest of a business, property or asset is transferred from one person or entity to another. Individual practitioners working for a facility or group can't undergo a CHOW. However, individuals operating as sole proprietors may undergo a CHOW by transferring their practice.

Facilities, ancillary providers and professional groups that have a CHOW need to complete a CHOW Notification Form no less than 60 calendar days before the change becomes effective. If you don't send us the form within this period, your reimbursement rates and claims payments may be affected.

The CHOW process applies to all lines of business, but different policies and procedures only apply to certain lines. Please refer to the resources below:

- **CHOW Faqs**
- **CHOW Form**

Commercial

- **Commercial PAM: Section XXIII-Attachment II**

BlueCare and TennCare*Select*

- **BlueCare PAM: Section XXVII-Attachment III**
- **Note: BlueCare providers must also notify TennCare of the CHOW.**

Reminders and Updates to Supervising Physician Requirements

Remember, Tennessee state law requires Nurse Practitioners and Physician Assistants to have a supervising physician. We also require your supervising physician to be contracted or credentialed with us.

You must maintain the name of your supervising physician on the State of Tennessee (or applicable state) licensure website in accordance with the law. We also ask you to add your supervising physician information to your CAQH profile during your next attestation and update it anytime it changes. Starting in 2025, NCQA will require providers with a CAQH application to verify their provider data at least every 180 days. With this change and the availability of current data on CAQH, we'll no longer directly collect the name of your supervising physician during the credentialing process.

Taxonomy Code Reminder

As a reminder, professional claims require a taxonomy code (a unique 10-character code that designates your classification and specialization) for billing and rendering providers. The **National Plan and Provider Enumeration System (NPPES)** directory shouldn't be the single source of determining the correct taxonomy.

It's important for both the billing and rendering provider taxonomy codes to match how you're credentialed and contracted with us. For example, if you have a pharmacy, specialty pharmacy and durable medical equipment (DME) provider contract, you'll need to file with the specific taxonomy indicated for each contracted service. If you don't submit the appropriate taxonomy codes, your claims may be rejected or denied, or result in reduced reimbursement.

Please be sure to file the two-digit qualifier with taxonomy.

Update CAQH With All Credentialing/Recredentialing Documentation

Please be sure to update CAQH with all information needed to be credentialed or recredentialed with us. This information includes, but isn't limited to, the name and NPI of the supervising physician, name and NPI of the person providing call coverage or covering for the colleague, certificate of insurance, and all certifications needed to process the request.

As of **Sept. 1, 2024**, we're no longer accepting documentation that can be updated in CAQH via email. All credentialing or recredentialing updates must be made and attested to in CAQH. As a reminder, it's important to keep CAQH updated with all necessary information to ensure our data is as accurate as possible.

Commercial

This information applies to Blue Network P℠, Blue Network S℠, Blue Network L℠ and Blue Network E℠ unless stated otherwise.

Telehealth Options for Follow-Up Appointments

Attending a follow-up appointment shortly after visiting the ER can be challenging for many members. That's why we're offering a new option to help. Patients who need a Follow-Up After Emergency Department Visit for Mental Illness (FUM) or Follow-up After Emergency Department Visit for Substance Use Disorder (FUA) can now take advantage of telehealth services. This means they can meet their follow-up requirements through telehealth visits, e-visits or virtual check-ins.

When scheduling a follow-up visit, it doesn't have to be with a behavioral health specialist. Any provider can conduct the visit if the primary diagnosis on the claim is related to the measure (behavioral health or substance use). Even if there's a short turnaround time, any visit within seven days of the ER visit, including the day of the ER visit, will count toward the 30-day follow-up requirement.

Understanding the Financial Responsibility Form and Prior Authorizations

Sometimes our members choose to pay for services that aren't covered by their plan. To make sure they understand potential financial commitments, have them sign the Acknowledgement of Financial Responsibility Form. Your patients must sign this form before requesting an uncovered service.

Even if patients agree to pay out-of-pocket, providers still need to complete the prior authorization process. The form doesn't waive this requirement. And it's important for the provider to complete the prior authorization process to make sure members don't self-pay and that they get any benefits available under their plan.

If you need more information on how to use this form, contact your Provider Network Manager.

Save Time on High-Tech Imaging Authorizations

Not all our plans require prior authorization for High-Tech Imaging (HTI). To see if your patient's plan requires one, log in to Availity, click the Prior Authorization Requirements button and then look for the **High-Tech Imaging** section.

If a prior authorization is necessary, here are some tips for faster approval:

- Please be sure to enter an individual provider number as the Requesting Provider instead of your group or facility. Unfortunately, provider group numbers display as out of network in our system, even if that's not the case.
  - If you don't know your BlueCross Provider Number, you can search for it by using the magnifying glass icon.
  - Or your network manager can give you a list of your organization's providers and their corresponding numbers.
    - Using one Requesting Provider for all a group's HTI authorizations can simplify the process.
  - **Don't** enter your group as the Requesting Provider or the Facility. Doing so may delay your authorization.
- If the place of service will be an office, you can skip the **Facility** field.
- If the place of service will be a facility, enter the appropriate facility information into that field and select the corresponding place of service.
- Claims will match up to the authorization because the individual provider number is tied to your Organization Tax ID number.
- Letters may be viewed on the **Auth Inquiry/Clinical Update** section of the authorization application.
- Important Reminder – our on- and off-Marketplace members don't have out-of-network or out-of-state benefits. These members must be seen by in-network, in-state providers.

New High-Tech Imaging Prior Authorization Vendor Effective Jan. 2025

Starting **January 2025**, Cohere Health will manage High Tech Imaging (HTI) prior authorizations for our Commercial line of business.

For your convenience, you'll continue to submit HTI requests directly to us through Availity or by calling **1-800-924-7141**. At that time, you'll be routed directly to Cohere.

If you have questions about using Availity, please call **(423) 535-5717, option 2**, or contact your **eBusiness Regional Marketing Consultant**. You can find additional training about the Cohere process mid-December in our Availity Resources section.

Federal Employee Program (FEP) Implements Changes for U.S. Postal Service (USPS)

Starting **Jan. 1, 2025**, FEP is offering a new Postal Service Health Benefits (PSHB) plan for USPS employees and retirees, as well as their eligible family members. While PSHB will be part of the overall Federal Employees Health Benefits program, it will be a separate plan from those offered to other federal employees in the program.

Transitioning PSHB members will continue to use Blue Network P so there will be no network changes. Additionally, benefits/coverage will remain the same and members will still use their current FEP-branded Member ID cards. The only change will be a new group number. Network P providers could start seeing PSHB members as early as Jan. 1, 2025.

For questions prior to Jan. 1, 2025, please contact FEP customer service at **1-800-572-1003**. After Jan. 1, 2025, providers with questions about PSHB should call **1-866-780-7742**.

BlueCare Tennessee

This information applies to BlueCare℠, TennCareSelect and CoverKids plans unless specifically identified below.

EPSDT Documentation and Claims Tips

Document All Seven Components of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Exams

When a patient visits your office for their well-child checkup, please document all seven required parts of the exam, as well as assessments of their nutrition and physical activity. Each exam should include documentation of:

- Comprehensive health (physical and mental) and developmental history
  - Initial and interval history
  - Developmental/behavioral assessment
- Comprehensive, unclothed physical exam
- Vision screening
- Hearing screening
- Lab tests
- Immunizations
- Health education/anticipatory guidance

Claims submitted for EPSDT visits must match your patients' medical records and contain codes for all parts. Additionally, your patients' medical records should match the EPSDT record you send us and include all care given during the exam.

If you're unable to complete a checkup because a patient is uncooperative, deferred or refused any part of the exam, please be sure to include this information in the patient's medical record.

For more information, view our **Partners in Prevention** booklet for providers.

Behavioral Health Provider Initiated Notice

The **Provider Initiated Notice (PIN) form** may now be attached to the Member Authorization on Availity. Simply look up the existing authorization and attach the PIN form in the **Clinical Update** section. The **Quick Reference Guide** is housed on **Availity Payer Spaces** under the **Resources** tab. If you have Availity questions or would like training for your organization, please contact your **eBusiness Regional Marketing Consultant**.

Encourage Patients to Get Their Flu Shot Today

With flu season underway, it's important to encourage patients to get their flu shot if they haven't already. Here are some key points to share with your patients.

Why get the flu shot?

- **The flu shot is one of the best ways they can protect themselves against the flu.** It can help reduce their risk of getting the flu. And if they do get the flu, the shot can help prevent serious illness, hospitalization and other severe complications.
- **Getting the flu shot can help protect others.** By getting vaccinated, patients help protect those who are more vulnerable, such as the elderly, young children and people living with chronic health conditions.
- **The flu shot is especially important for patients who are pregnant.** Pregnancy can make the body more susceptible to severe illness from the flu and increase the risk of hospitalization. The flu may also harm the developing baby. The flu shot can help reduce these risks. Plus, getting vaccinated during pregnancy can help protect the baby after birth, as maternal antibodies are passed on to the newborn.

Let's work together to make this flu season as safe as possible for everyone.

Resources for Patients Transitioning Out of Foster Care

We're here to make the transition from foster care to adulthood easier for your patients. Our team works closely with the Department of Children's Services (DCS) to ensure these young adults are connected to community resources and other programs, depending on their health needs.

TennCare benefits

Patients aging out of foster care may be eligible to stay on a TennCare plan until age 26.

If they still live in Tennessee after they turn 18, they'll automatically be approved for TennCare until age 26. They'll need to reapply if they:

- Were in foster care at age 18 or older and getting Medicaid in another state after Jan. 1, 2023.
- Moved to another state and then moved back to Tennessee.

They can confirm the status of their health coverage by calling TennCare Connect at **1-855-259-0701**, visiting **tenncareconnect.tn.gov** or contacting their DCS representative.

Independent living

Teens ages 14-16 will work with the DCS Independent Living division to develop an independent living plan, and starting at age 17, a transition plan. Depending on each teen's needs and goals, these plans can help with:

- Life skills
- Education – high school and beyond
- Driver's education and license
- Housing
- Employment
- Medical and behavioral health care
- Applying for Social Security benefits

Extra support

We can also help connect patients to programs that provide extra support, like Employment and Community First CHOICES for people with intellectual and developmental disabilities, and community agencies that can help with housing, transportation, food, utilities and dental care.

You can find more resources for children and young adults in oster care on our website. Just go to **bluecare.bcbst.com/foster**.

Note: The information in the article above only applies to TennCare*Select*.

Use the QCR Application to Refer Patients for Case Management

Primary care providers can now use the Quality Care Rewards (QCR) application in Availity to refer patients enrolled in BlueCare or CoverKids for case management services. You can also use this application to see:

- Patients enrolled in case management
- Patient case management history
- Prior referrals and referral reason
- Name and contact information of the case manager for more complex needs

To start a referral, choose **Case Management** from the Availity home screen. Then, select the patient you'd like to refer for services, choose **Case Manager Referrals**, then choose **Make a Referral**. To complete the referral, you'll need to share your contact information and details about support the patient may need. Example referral reasons may include:

- Disease management
- Coordination of medical and social services
- Referrals to community-based resources
- Facilitate access to services
- Increase patient knowledge/compliance with treatment
- Discharge planning
- Medication management
- Meeting condition-specific needs

Once you've submitted the referral, you'll get a confirmation. You'll also be able to view the referral on the **Case Management Referrals** tab.

Once we receive the referral, we'll contact the patient or their preferred contact person for the follow up questions as needed. If you have questions about using the QCR application, please contact your eBusiness Regional Marketing Consultant or call **(423) 535-5717, option 2**.

Non-Discrimination Compliance Training Reminder

We encourage all providers who participate in BlueCare, TennCare*Select*, CoverKids, CHOICES or Employment and Community First (ECF) CHOICES to complete your annual non-discrimination compliance training. You can find the Non-Discrimination Compliance Information for Providers presentation at Documents and Forms under **Required Training & Health Equity** on the BlueCare provider website.

BlueCare Plus Tennessee

This information applies to our Medicare and Medicaid dual-eligible special needs plans unless specifically identified below.

2024 Special Needs Plan Model of Care (MOC) Training Still Available

Providers participating in BlueCare Plus Tennessee special needs plans are contractually required to complete our MOC Training after initial contracting, then every year afterwards. This training promotes quality of care and cost effectiveness through coordinated care for our members with complex, chronic or catastrophic health care needs. You can access the online self-study training and attestation at **bcbst.com/model-of-care-training**.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ plans unless specifically identified below.

New In-Home Chronic Wound Care Program

As of Oct. 1, 2024, you can refer your patients with Medicare Advantage coverage who need chronic wound care to Esperta Health. Those interested in participating in the program must live in Middle or West Tennessee.

Esperta Health is a specialty physician practice working with us to deliver a complete wound care program to your patients in the comfort of their home. This program ensures your patients receive expert care from wound-certified specialists who can treat, heal and prevent their chronic wound from recurring.

Chronic wounds approved for referral:

- Diabetic ulcers
- Arterial ulcers
- Venous ulcers
- Pressure injuries or ulcers
- Chronic venous insufficiency ulcers
- Malignancy-related ulcers
- Lymphedema-related ulcers
- Surgical wounds
- Burns
- Atypical wounds
- Autoimmune wounds
- Wounds caused by infections
- Non-healing wounds
- At-risk wounds*

How to refer chronic wound patients to Esperta Health:

- Online at **espertahealth.com/referral**
- By phone at **1-833-377-3782**
- Faxing a patient referral to **(615) 278-1860**
- Emailing **customerservice@espertahealth.com**

For more information about Esperta Health, please visit **espertahealth.com**.

*At-risk wounds include multiple or significant patient co-morbidities, recurrent infections, prior amputation(s), history of wound-related hospitalization, poor nutrition or a weakened immune system. A weakened immune system can be caused by chronic illnesses such as cancer, diabetes and COPD, or by using immunosuppressant medications like steroids and biologics.

Medicare Advantage 2025 Quality Program Measures

Beginning **Jan. 1, 2025**, the following changes will be made to the quality measures included in the Medicare Advantage Quality+ Partnerships program:

- The **Polypharmacy – Multiple Anticholinergic Medications (Poly-ACH)** measure will move from the monitoring section to the second section of the program as a single-weighted measure.
- The **Glycemic Status Assessment for Patients With Diabetes (GSD)** measure will replace the Hemoglobin A1c Control for Patients With Diabetes (HBD) measure.
- The **Notification of Inpatient Admission (NIA)** and **Receipt of Discharge Information (RDI)** components will be removed from the scoring of the Transitions of Care (TRC) measure.
- The **Member Experience – CAHPS (BlueCross CMS Score/Mock Survey)** measure weight reduces from 4 to 2.
- The following measures will be added to the Monitoring Status Only section of the scorecard:
  - **Concurrent Use of Opioids and Benzodiazepines (COB)**
  - **Member Experience – HOS: Improving or Maintaining Mental Health**
  - **Member Experience – HOS: Improving or Maintaining Physical Health**

The 2025 program year measures are listed below in order of measure weight:

Measure	Source	Weight
Controlling High Blood Pressure (CBP)	HEDIS	3
Glycemic Status Assessment for Patients With Diabetes (GSD)	HEDIS	3
Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) Files	3
Medication Adherence for Hypertension (RAS Antagonists)	Prescription Drug Event (PDE) Files	3
Medication Adherence for Non-Insulin Diabetes Medications (OAD)	Prescription Drug Event (PDE) Files	3
Plan All-Cause Readmissions (PCR)	HEDIS	3
Member Experience - CAHPS	CMS Member Survey	2
Member Experience - HOS	CMS Member Survey	2
Breast Cancer Screening (BCS)	HEDIS	1
Colorectal Cancer Screening (COL)	HEDIS	1
Eye Exam for Patients With Diabetes (EED)	HEDIS	1
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)	HEDIS	1
Kidney Health Evaluation for Patients With Diabetes (KED)	HEDIS	1
Osteoporosis Management in Women Who Had a Fracture (OMW)	HEDIS	1
Polypharmacy – Multiple Anticholinergic Medications (Poly-ACH)	Prescription Drug Event (PDE) Files	1
Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy (SPC)	HEDIS	1
Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) Files	1
Transitions of Care (TRC)	HEDIS	1

Please contact your Medicare Advantage Provider Quality Outreach Consultant for more information or questions about the measures included in the 2025 quality program.

Complete 2024 Provider Assessment Forms (PAFs)

It's not too late to complete and submit your PAFs for 2024. You can complete them during a face-to-face or telehealth visit with both audio and video components. You may complete the assessment forms in conjunction with a Medicare annual wellness visit or any other office visit type.

You can find and fill out the hierarchical chronic condition PAF in the Quality Care Rewards (QCR) application in Availity. Be sure to keep a copy of the PAF in the patient's medical record. **Note:** Office visit notes aren't accepted for PAFs.

Submit CPT® code 96161 and the appropriate visit Evaluation and Management code once the electronic PAF is submitted. No modifier is needed. Completed electronic PAFs are reimbursed at $225 each for dates of service Jan. 1 through Dec. 31, 2024.

Please contact your Provider Quality Outreach Consultant if you need help with PAFs.

Medicare Prescription Payment Plan

The **Medicare Prescription Payment Plan** is a new payment option outlined in the Inflation Reduction Act. It works with a member's drug coverage to help them better manage their Part D drug costs by spreading out-of-pocket Part D drug costs out over the year in the form of monthly payments, rather than up front at the pharmacy.

Starting in 2025, anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can participate. All Medicare Advantage Prescription Drug Plans and standalone prescription drug plans offer this payment option, and members can choose whether to participate. Members don't pay anything extra to enroll in the Medicare Prescription Payment Plan.

When a member fills a prescription for a covered Part D drug, they won't pay anything at the pharmacy (including mail order and specialty pharmacies). Instead, we'll send them a bill each month.

Even though they won't pay for their drugs at the pharmacy, members are still required to pay the same total amount for their drugs. This payment plan can help them manage their monthly expenses, but it doesn't save them money or lower their drug costs.

Members can call the Member Service number on the back of their Member ID card to start the enrollment process. If they'd like to join:

- **In 2024, to participate starting Jan. 1, 2025**, they can contact us now.
- **During 2025**, members can call us any time.

Medicare Advantage and Dual Special Needs Plans

This information applies to our BlueAdvantage and BlueCare Plus Tennessee plans unless specifically identified below.

Providers Must Be Enrolled with CMS as Medicare Providers to Participate in Senior Care Networks

According to the Centers for Medicare & Medicaid Services (CMS), providers must be enrolled in traditional Medicare with CMS to be eligible to participate in our Medicare Advantage and Dual-Eligible Special Needs Plan networks.

In the coming months, we're auditing these networks to make sure our providers are eligible. We'll notify providers who aren't enrolled in traditional Medicare with CMS and give them a chance to enroll and provide us with proof of enrollment. If providers choose not to enroll, we may have to terminate their provider agreements for these networks.

For more information, providers should contact their Provider Network Manager.

Peer-to-Peer (P2P) Review Process Updates

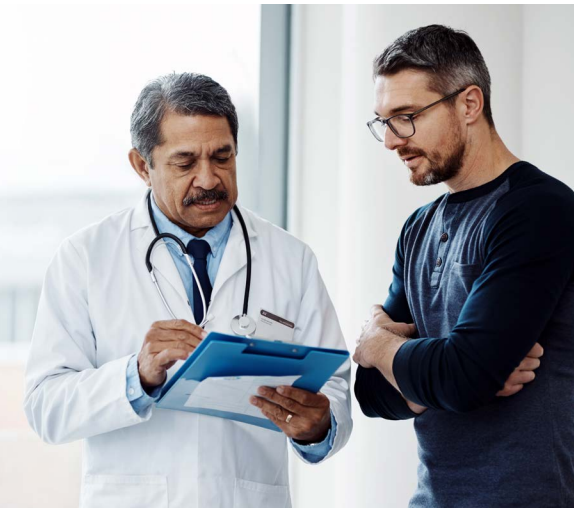
We're updating the P2P review process. Beginning Jan. 1, 2025, P2P requests must be submitted within five business days of the discharge date. A P2P review won't be scheduled if you submitted a written appeal at the same time.

A P2P conversation allows requesting physicians to share critical information that may have been omitted from the original request for services. It's not an appeal, not specialty matched and not intended to overturn a denial. For Medicare Advantage plans, discussion must be completed prior to the adverse determination being rendered. Once an adverse determination has been made for pre-service, concurrent and retrospective cases, participating providers can submit a dispute through the appropriate appeal process.

For pre-service requests, the P2P review must occur before the whole or partial denial determination is rendered. For requests where a determination has been made, P2P reviews will only be offered for inpatient post-service requests, where a decision was rendered, and the member has been discharged.

Pharmacy

This information applies to all lines of business unless specifically identified below.



Humira® Leaving Our Preferred Formulary

Effective Jan. 1, 2025, we'll remove Humira from our Preferred Formulary. Instead, we'll cover three biosimilars:

- Simlandi
- Adalimumab-adaz
- Hadlima

Please talk to your patients who are currently taking Humira to see which covered biosimilar is right for them. You'll need to provide a new prescription for the biosimilar chosen. We'll automatically batch load prior authorizations for all patients currently taking Humira, which will be valid through the original approval date for Humira.

Refer to the TennCare Pharmacy Benefit Manager for Important Updates

Please **click here** to review important notices about prescribing changes, authorization guidelines and other items related to the TennCare Pharmacy Program.

Tips for Coding Professionals

This information applies to all lines of business unless specifically identified below. Please note these tips are educational only, providers remain responsible for completion of claims submitted to BlueCross.

Coding Updates: See the Latest and What Changes Are on the Way

You can easily find current coding updates and pending claim edit changes under **Coding Updates** in the Coding Information section of our **Coverage & Claims** page. You can access code edits 60 days before the effective date. If you have questions, please call us at **1-800-924-7141** and follow the prompts for providers (**option 1**).

BlueCross BlueShield of Tennessee, Inc., BlueCare Tennessee and their licensed health plan and insurance company affiliates comply with the applicable federal and state laws, rules and regulations and does not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability. If a member or participant needs language, communication or disability assistance, or to report a discrimination complaint, please, call **1-800-468-9698** for BlueCare, **1-888-325-8386** for CoverKids or **1-800-263-5479** for TennCare*Select*. For TTY help call **771** and ask for **1-888-418-0008**.

This information is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee, Inc. or any of its licensed affiliates. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member's ID card.

Archived editions of BlueAlert are available **online.**

Contact Us Through Availity

Availity® makes it easy for you to do business with us online anytime, offering faster prior authorizations, claims decisions and more. You can log in at **Availity.com** to:

- Check benefits, eligibility and coverage details
- Manage prior authorizations
- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
- Manage your contact preferences

CAQH Solutions | PROVIEW™

Be sure your **CAQH ProView**™ profile is kept up to date at all times. We depend on this vital information.

Provider Service Lines:

Featuring "Touchtone" or "Voice Activated" Responses

Commercial Service Lines	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
Commercial UM	1-800-924-7141
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	
Federal Employee Program	1-800-572-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)	
BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978
CoverKids	1-800-924-7141
CHOICES	1-888-747-8955
ECF CHOICES	1-888-747-8955
Monday–Friday, 8 a.m. to 6 p.m. (ET)	
BlueCare Plus℠	1-800-299-1407
Seven days/week, 8 a.m. to 6 p.m. (ET)	
***Select*Community**	1-800-292-8196
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
BlueCard	
Benefits & Eligibility	1-800-676-2583
All other inquiries	1-800-705-0391
Monday–Friday, 8 a.m. to 6 p.m. (ET)	
BlueAdvantage	1-800-924-7141
Seven days/week, 8 a.m. to 9 p.m. (ET)	
eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
Email:	**eBusiness_service@bcbst.com**
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	

Important Note:

If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice or facility:

Please visit our payer space at **Availity.com** and update your information.

Update your provider profile on the **CAQH Provider Portal** website.

Questions? Call **1-800-924-7141**.