of Tennessee

APRIL 2025

BlueAlert℠

of Tennessee | 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.

Find COVID-19 Updates from BlueCross

For the past five years, we've maintained a website dedicated to COVID-19 information and policy updates for our providers and members. Effective **April 1, 2025**, we're retiring this website. You can now find information related to our COVID-19 coverage and policies for all lines of business in our Provider Administration Manuals or at **provider.bcbst.com**.

INSIDE THIS ISSUE

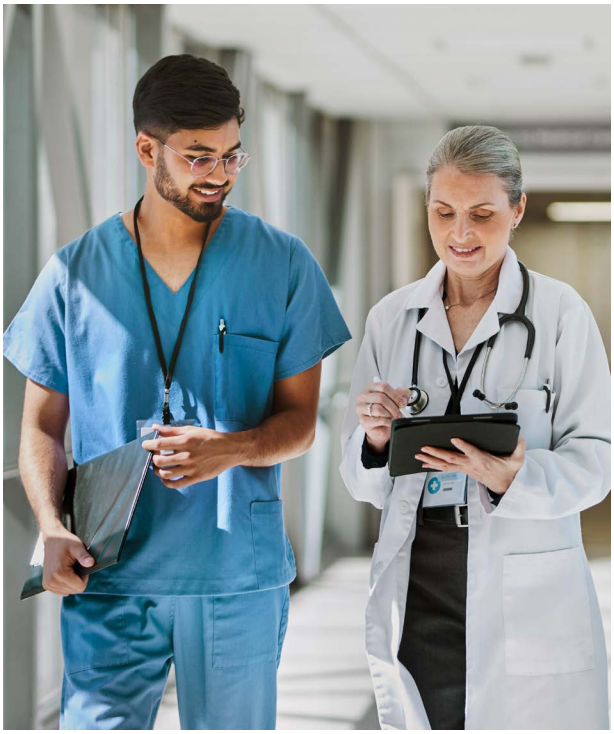
Change of Ownership Requirements

Anyone acquiring a provider facility or group must give us at least 60 days advance notice of change of ownership (CHOW). If you're acquiring more than 25% control of a provider facility or group, you also need to submit a CHOW notification using the **Provider Change of Ownership Notification Form**. Additionally, once the transaction has closed, send us a copy of the executed bill of sale or purchase document (minus the purchase price) within five business days of closing. If you don't provide the required notice or documents, your payments could be impacted.

A CHOW is defined as:

- Direct or indirect sale or other disposition of all or a majority of the assets of a provider;
- Any transaction resulting in a change in the beneficial owner, directly or indirectly, of more than 25% of the then-outstanding number of units, interests or shares of the provider's voting stock (or membership interests or other equity);
- Conversion – Changing from one legal entity type to another (i.e., conversion from partnership to corporation or conversion from corporation to a limited liability company);
- The lease of all or part of the provider's facility; or
- Any other transaction that results in a change to the NPI or Tax ID of a provider.

You can also find additional information in the Frequently Asked Questions **here**.



Submitting Paperwork Attachments (PWK)

If you need to submit paper documentation to support an electronic claim, like an invoice, it's important to follow the correct steps. You can find the detailed instructions **here**.

If you have any questions about these instructions or the correct use of PWK, please contact eBusiness Service at **(423) 535-5717, option 2**, or **eBusiness_Service@bcbst.com**.

Save the Date – 2025 All Blue Workshop℠

On **Thursday, Aug. 14, 2025**, we're hosting our annual All Blue Workshop. Join us for an all-day virtual event where we'll discuss the latest news, updates and topics important to you and your practice. You can also ask questions about working with BlueCross. Registration opens soon. Be sure to look for more information in future BlueAlert issues. We look forward to seeing you online.

Inclusive or Exclusive Billing for Behavioral Health Psychiatric Facilities

Please review the following guidelines for institutional and professional providers to ensure you're billing for inclusive services correctly.

Institutional providers (psychiatric hospital, residential treatment center, other psychiatric outpatient facility):

Your contract with us includes details about inclusive or exclusive service billing. You can find information under each section of your contract addressing your rates for each service, such as inpatient, intensive outpatient and partial hospitalization.

If the language about the rate for a particular service denotes it as **inclusive**, all professional or physician services must be provided as part of that rate. You shouldn't submit another claim for professional or physician services rendered in your facility as part of the service you're providing. Please ensure providers supporting these services are aware of the inclusive agreement.

Professional providers (psychiatrists, nurse practitioners, psychologists, therapists, primary care physicians):

When providing services at a psychiatric hospital, residential treatment center or other psychiatric outpatient facility, please confirm with the facility if professional services should be billed separately. If you're providing services at a facility whose rates are inclusive of professional services, you can't file a separate claim. Any amount we pay you for your service with this facility is subject to an overpayment recovery.

If you have questions, please contact your provider network manager.

Commercial

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

Enhanced Clinical Editing Processes

Beginning in **June 2025**, we're enhancing our Commercial post-payment reviews of paid medical claims to verify payment accuracy. These reviews will align with the Utilization Management Program outline in your Provider Administration Manual (PAM) (VII. Utilization Management Program; H. Prospective and Retrospective Review; K. Transparency).

We're working with Cotiviti Corporation, a market leader in payment integrity, to audit Commercial Diagnosis Related Group (DRG) claims for accuracy. We've already performed post-payment DRG audits on our government lines of business.

Similarly to the government lines of business DRG audits, we'll include information about where to submit reconsiderations in your financial recovery notice. The process will follow the Provider Dispute Resolution Process and timelines outlined in the PAM. If you disagree with a determination, you have the right to appeal in accordance with PAM guidelines.

If you have questions, please contact your Provider Service Representative.

Find Upcoming Prior Authorization Changes

You can easily find the latest changes to prior authorizations under **Upcoming Prior Authorization Changes** in the **News & Updates** section of our **Documents & Forms** page. Prior authorization changes are published at least 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)**.

Save Time With High Tech Imaging Prior Authorizations

Please be sure to find out if your patients have High Tech Imaging (HTI) prior authorization requirements before starting the authorization process. Not all our Commercial plans require HTI authorization, and checking on this can save you some time.

You can check when you log in to Availity® to verify patient benefits. Just click the blue button labeled **Prior Authorization Requirements**, then look for the **High Tech Imaging** category. If **Yes** is listed, an authorization is required, and you should continue with the process. If **No** is listed, an authorization isn't required.

If you have questions, please call **(423) 535-5717**, **option 2**, or contact your **eBusiness Regional Marketing Consultant**.

BlueCare Tennessee

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

Dedicated Staff to Support Children in Foster Care

We have a specialized team to help foster families and our members in state custody. Our *Select*Kids team can help with scheduling appointments, out-of-state pharmacy needs, and addressing social determinants of health. They can also connect families to our care team as needed for help with healthy living, managing short- or long-term illness or injury, or more complex health needs.

Additionally, our *Select*Kids team works closely with the Department of Children's Services (DCS) and can serve as a liaison if you'd like extra support coordinating patient care.

Please let foster families know we're here to help. You and your patients' guardians can reach our care team by emailing **SelectKids_GM@bcbst.com** or calling **1-877-DCS-KIDS (1-877-327-5437)**. We're available Monday through Friday from 8 a.m. to 6 p.m. ET. After hours, calls are automatically routed to our Nurseline.

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

Updated Billing Guidance: Provider Maternity Payments

We're making changes to the billing instructions for you to earn extra payments associated with prenatal and postpartum care. These changes allow us to align our billing guidance with the other TennCare managed care organizations (MCOs) and will make it easier for providers who work with more than one MCO to bill for extra payments.

Effective **April 1, 2025**, you'll need to take these steps to file a claim for prenatal payment:

- Continue to submit charges with the Category II code 0500F and its associated $25 payment on the claim.
- Submit evaluation and management (E/M) codes 99202-99205 or 99211-99215 on the claim.
- Send the Maternity Care Notification Form through Availity within 30 days of submitting the claim.

What's changed: You no longer need to include the date of the last menstrual period on the claim.

Also, effective **April 1, 2025**, you'll need to take these steps to file a claim for postpartum payment:

- Continue to submit charges with the Category II code 0503F and its associated $75 payment on the claim.
- Submit E/M code 59530 on the claim.
- During the postpartum period (seven to 84 days after delivery), providers may submit two claims and earn two payments for postpartum care.

What's changed: You no longer need to include the delivery date on the claim.

We're updating our materials to reflect this new guidance. For more information about payments and billing instructions, please see our **Maternity Support webpage**.

Save the Date: Lunch and Learn Event for Maternal Health Providers

We're hosting a Maternal Health Substance Use Disorder/ Opioid Use Disorder Lunch and Learn for providers located in Middle and East Tennessee. The event is scheduled for **Monday, April 7, 2025**, at 12 p.m. ET and will include:

- BlueCare Tennessee Behavioral Health
- ReVIDA® Recovery Center
- Vanderbilt's Firefly program
- Q&A

Registration is required, and you can sign up **here**.

Coding for Sickle Cell Disease

To help make sure claims for sickle cell disease are coded correctly, we've put together some information about the ICD-10 codes. The ICD-10 code for sickle cell disease is D57, with further specifications depending on the presentation, i.e. crisis or without crisis. The code for sickle cell trait is D57.3.

If you see a coding error related to sickle cell, see if it uses the correct subtype code under D57 or if it uses D57.3 for sickle cell disease rather than sickle cell trait.

Here's some more information about sickle cell coding:

- General code: D57
- Sickle cell trait: D57.3
- Sickle cell disease without crisis: D57.1
- Sickle cell disease with crisis: D57.0

We've developed a provider guide that includes information about sickle cell disease, treatment, prior authorization and more. You can view it **here**.

Optum® Provider Claim Review

We're required to submit diagnostic data for our members enrolled in certain Medicaid health plans. Optum may contact you within the next few weeks with a request to review and confirm information if a difference is found between medical records and claims you've submitted.

Optum will coordinate this provider claim review (PCR) by:

- Coordinating the review and confirmation of adjusted claims when coding results indicate a discrepancy in risk-adjusted diagnosis codes.
- Identifying diagnosis codes from patient visits during chart review and creating an adjusted CMS-1500 claim form for you.
- Working with you to determine the appropriate person to receive these claims and explain the PCR process.

If Optum contacts you, we'll need you to review and confirm the information on the adjusted claim and submit it through the PCR process by the date requested.

If you have questions, please see the Optum Reference Sheet on the **Documents and Forms page** of **bluecare.bcbst.com/providers**. To find it, click **Administrative Information**, then choose the **Office Administration** drop-down menu. Or contact your Optum business operations specialist at **1-866-985-8462**.

Updated Population Health Resource

We've recently updated our Population Health Brochure for providers. It includes helpful information about the support we give to patients with chronic or complex health needs, including:

- Our care team
- Virtual solutions for digital case management
- Case management referral options for primary care providers

If you have questions about the information covered, please call the Provider Service line for your patient's plan.

Using EPSDT Visits to Address Minority Health Disparities

April is National Minority Health Month, a time to raise awareness of the health disparities that racial and ethnic minorities face. These disparities extend to children and adolescents.

Consider these key facts about child and adolescent well-care in Tennessee, as highlighted in our **2025 Health Equity Report**:

- Only 12% of Black adolescents had a flu immunization during the 2022–2023 flu season
- In 2023, 14.7% of Hispanic children in Tennessee did not have health insurance
- In 2022, 17.6% of Tennessee's children were living below the poverty level compared to 16.3% of children in the U.S.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits can help address gaps in care among minorities and counter these disparities.

Emphasizing the importance of EPSDT visits to parents during their children's early years may encourage them to keep more regular appointments. Regular EPSDT visits during childhood may result in improved rates of immunizations, screenings, physical exams, lab tests and health education for children and adolescents across Tennessee.

Note: The information in this article doesn't apply to CoverKids.

Improving Maternal Health Among Black Women

The CDC designates April 11-17 as Black Maternal Health Week. This yearly recognition raises awareness of maternal health disparities faced by Black women.

According to the Tennessee Department of Health's **2024 Maternal Mortality in Tennessee Annual Report**, 76% of all pregnancy-related deaths in 2022 were preventable, exposing the need for better prenatal care among expecting patients. The report also highlighted maternal mortality disparities between racial and ethnic groups, with non-Hispanic Black women bearing the greatest burden.

From 2020 to 2022, non-Hispanic Black women experienced the highest rate of pregnancy-related deaths compared to other groups — 1.8 times higher than non-Hispanic White women and 2.9 times higher than Hispanic women. Cardiovascular conditions accounted for 30% of these deaths and were the largest contributing factor. Infection was the second-largest contributor, accounting for 27%.

Our own **2025 Health Equity Report** shows Black women in Tennessee are less likely to get prenatal immunizations, timely prenatal care and postpartum care than Asian, Hispanic and White women. Encouraging patients to get all recommended prenatal and postnatal care may serve to improve mortality rates across the state.

Covering for Another Primary Care Provider (PCP)

BlueCare Tennessee members can only see their assigned PCP or an affiliated, covering provider in our network.

Affiliated covering providers automatically include PCPs in the same group who have the same tax ID. If you're a PCP without a group affiliation, we can manually load covering providers based on information we receive from your office.

Before care is covered

If you're covering for another PCP, make sure you're listed as an affiliated, covering provider before giving care. You can check this information in Availity in the **Enrollment and Benefits** section.

You can also update your covering colleague's information using the **Individual Change Form**. You can find this form in the Availity **Provider Enrollment Updates and Change** application.

Please note, providers can only use this tool to make changes at the individual level – not the group level.

For more information on PCP assignment, click **here**.

TennCare Benefit Reminder: Diapers for Members Under Age 2

Your patients' BlueCare Tennessee and CoverKids benefits include diapers and training pants at no cost to them. The benefit covers up to 100 diapers per month from an approved list of products until age 2. To view the list of participating pharmacies and approved diapers, which include different types and brands, please visit **tn.gov/tenncare/diapers**.

To get the diapers, parents and guardians will simply need to present their child's pharmacy ID card at the pharmacy counter of participating locations. There's nothing required from you. Patients don't need a prescription, and diapers don't have a copay or count against our members' monthly prescription limit. If a newborn doesn't have a pharmacy ID card yet, parents can present the mother's pharmacy ID card or the child's Social Security Number.

Please let your patients know about this benefit. If they have questions, please ask them to call the Member Service number on the back of their member ID card or visit **tn.gov/tenncare/diapers**.

Your Source for Division of TennCare Announcements

You can view announcements from TennCare in the **News and Updates** section of **bluecare.bcbst.com/providers**. These announcements replace the TennCare Provider Experience newsletter. We'll update them quarterly, so check back frequently for news you need.

BlueCare Tennessee and BlueCare Plus Tennessee

This information applies to both BlueCare Tennessee and BlueCare Plus Tennessee lines of business.

Billing Requirement for Professional Claims

We'll soon begin applying claims edits to BlueCare Tennessee and BlueCare Plus Tennessee claims if the referring provider's NPI is the same as the billing or rendering provider's NPI. This helps us ensure compliance with the Division of TennCare's "Provider Identification Usage on Submitted Transactions Policy."

According to this policy, reporting the same provider NPI more than once on a single claim is incorrect. Exceptions include:

- Institutional claims where the operating or other operating physician may be the same as the attending provider.
- Professional claims where the supervising provider may be the same as the rendering provider.

BlueCare Plus Tennessee

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

2025 Special Needs Plan Model of Care (MOC) Training Now Available

Providers participating in BlueCare Plus Tennessee special needs plans are contractually required to complete our MOC training after initial contracting, then every year afterward. 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 by **clicking here**.

BlueCare Plus Tennessee and Medicare Advantage

This information applies to both BlueCare Plus Tennessee and Medicare Advantage lines of business.

Master Prior Authorization List Review and Upcoming Updates

In preparation for the 2025 Centers for Medicare & Medicaid Services (CMS) proposed rule changes related to prior authorization (PA), we're reviewing the **Master Prior Authorization List** to identify opportunities to reduce the number of services requiring prior authorization.

Effective **April 1, 2025**, we've removed the PA requirements from more than 3,000 codes. Many of those codes are related to durable medical equipment, orthotics and prosthetics, and CPT® codes identified on the CMS inpatient only code list (inpatient admission still requires PA).

We've created a **Master Prior Authorization List Code Removals** document with all codes that no longer require PA. You can find the most up-to-date lists on our **Authorizations and Appeals** provider site.

Medicare Advantage

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

Faster Decisions for Medicare Advantage Prior Authorizations

Looking to fast track authorizations? Many authorizations can be approved automatically if you choose the appropriate Local Coverage Determination guideline when submitting clinical information. Choosing the first guideline that appears can cause the authorization to pend for nurse review, delaying your approval. Try using the LCD guidelines when appropriate. If your request meets all the criteria, you may get instant approval. If you have questions, please call **(423) 535-5717, option 2**, or contact your **eBusiness Regional Marketing Consultant**.

Provider Approval Letter Notification Changes

Effective **April 1, 2025**, we no longer mail provider approval letters. Instead, we'll send a fax notification to the requesting provider. You can also view and print prior authorization letters in Availity.

To view prior authorization letters:

1. Log in to **Availity**.
2. Click on **Payer Spaces** and choose the **BlueCross BlueShield of Tennessee** logo.
3. Choose the **Authorization Submission/ Review** application.
4. Go to the **Auth Inquiry/Clinical Update** drop-down arrow. Then, choose **BCBST** to search for the existing authorization.
5. Next, choose the **case ID number** to view the authorization details.
6. Look for the letter section in the upper right to **view and print** the authorization letter.

If you have questions about the Availity process, please call **(423) 535-5717**, **option 2**, or contact your **eBusiness Regional Marketing Consultant**.

Provider Star Ratings Now Available in Availity

The Medicare Advantage Quality+ Partnerships Program offers providers enhanced reimbursement for 4-Star and above quality scores and coding accuracy completed during the 2024 measurement period of Jan. 1 – Dec. 31, 2024. Participating providers can now view their 2024 Star rating in Availity.

- Go to the **Quality Care Rewards** application.
- Click the **Scorecards** tile.
- Go to the **Prior Year Scorecards** link under the **More Information** tile.

The rating is located at the top of the scorecard.

Star ratings, as calculated by the previous year's performance, impact each provider's current reimbursement rates. New rates go into effect **April 1, 2025**. Providers should refer to the rate attachment provided with their rate adjustment notification letters, mailed at the end of March, to see their new fee schedules.

Contract amendments contain information about each provider's base rate, the quality escalator and total earning potential.

Quality Care Initiatives

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

Managing Patients on Antipsychotic Medications

Antipsychotic medications are crucial for treating mental health conditions, but they come with challenges. That can affect HEDIS® measures like Schizophrenia and Antipsychotic Medication Adherence (SAA), Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), and Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM).

For SAA, educate patients about the importance of sticking to their medication, potential side effects and benefits. Use tools like reminders and mobile apps to help them remember. Long acting injectables can be useful for those who struggle with adherence. Work closely with psychiatrists, PCPs and pharmacists to support patients.

For APP, prioritize psychosocial care like cognitive-behavioral therapy (CBT) and family therapy before prescribing antipsychotics. Keep detailed records of these interventions. Use CPT® codes 90832-90834 and 90836-90840 for reporting.

For APM, conduct regular metabolic screenings, including glucose levels, lipid profiles and BMI. Make these screenings part of routine care visits and involve parents in the process. Use CPT® codes like 82465, 83718 and 83722 for cholesterol tests, and 80047, 80048, and 80053 for glucose tests. HbA1c codes include 83036 and 83037, and LDL-C codes include 80061 and 83700. Use Z13.22 for screening metabolic disorders.

Managing patients on antipsychotic medications requires patient education, regular monitoring and collaborative care. By focusing on these strategies, providers can improve patient outcomes and ensure high-quality care.

Note: The information in this article applies to the Commercial line of business.

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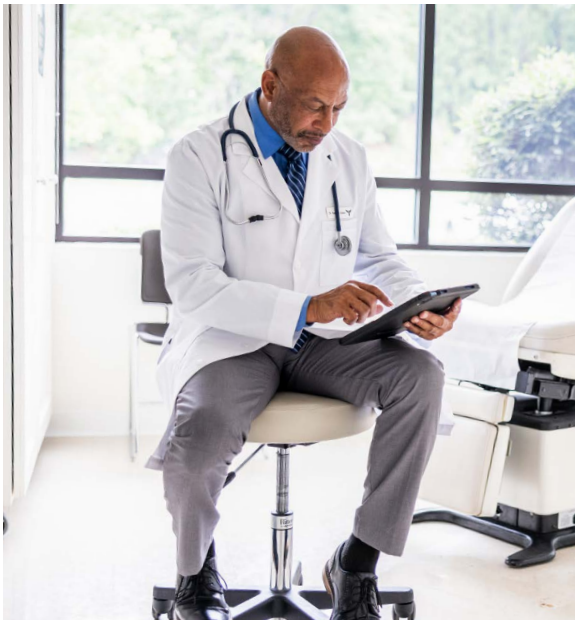

Updated Time Frame for Episodes of Care Appeals

We're changing the time frame for appealing information in your final Episodes of Care performance report. Effective **May 1, 2025**, you'll have 30 days from the date your final report is in Availity to appeal a gain- or risk-share payment. We'll then have 30 days to review and respond to your appeal.

This change aligns our processes with other MCOs and makes sure we're able to pay provider gain-share payments as soon as possible.

For more information about the Episodes of Care program, please see the **Quality Care & Specialty Initiatives** page of **bluecare.bcbst.com/providers**.

Note: The information in this article applies to BlueCare.

Quality Score Improvement Tips

Here are some tips to help you avoid the most common mistakes we see affect quality improvement scores:

1. **Controlling High Blood Pressure (CBP) or Blood Pressure Control for Patients with Diabetes (BPD):** Take it twice! The systolic reading must be 139 or less and the diastolic reading must be 89 or less. You can close the gap by using the lowest systolic and lowest diastolic reading from different BP readings if they're taken on the same date/visit. Example: If the first reading is 130/95 and the second is 156/80, the gap can be closed with a reading of 130/80.
2. **Kidney Health Evaluation for Patients with Diabetes (KED):** Patients are required to receive both an eGFR and a uACR during the measurement year on the same or different dates of service. The uACR must be identified by either of the following: Both a quantitative urine albumin test and a urine creatinine test with service dates four days or less apart or a urine albumin creatinine ratio lab test.
3. **Colon Cancer Screening (COL-E):** In-office Guaiac Test and fecal occult blood testing via digital rectal exam don't meet the measure criteria. Guaiac testing is acceptable if it's not collected in the office and there are at least three samples returned. It can be tested in the office when the patient returns the cards.
4. **Adult Immunization Status (AIS-E):** You must document the actual date the immunization was given to close the gap. Stating "up to date" or "patient declined" will not close the gap.
5. **Glycemic Status Assessment for Patients with Diabetes (GSD):** A1C levels of 8 or higher won't close the gap in care. Include numeric value; ranges and thresholds do not meet criteria (e.g., < 9.0 % is not acceptable).

If you have questions about measure guidelines, reach out to your Commercial Quality Improvement team at **GM_Commercial_Quality _Improvement@bcbst.com**.

Note: The information in this article applies to the Commercial line of business.

Pharmacy

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

Step Therapy for Additional Medicare Part B Drugs

Effective **April 1, 2025**, Medicare Advantage and BlueCare Plus Tennessee will require prior authorization and step therapy for two more Part B drugs: Hercessi™ and PiaSky®. This will affect members who are new to therapy.

You can find more information in our **Step Therapy Requirements for Medicare Outpatient (Part B) Medications** guide. If you have questions, contact your Provider Service Team.

Humira® No Longer on Preferred Formulary

Effective **Jan. 1, 2025**, we removed Humira from our Preferred Formulary. Instead, we're covering three biosimilars:

- Simlandi
- Hadlima
- Adalimumab-adaz

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**.