of Tennessee

FEBRUARY 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.

INSIDE THIS ISSUE

About the Provider Exclusion Screening Process

The health and safety of our members and your employees are important, which is why we'd like to remind you of your contractual obligation to screen all employees, agents and contractors (Exclusion Screening Process) against the exclusion lists.

You also need to conduct criminal background checks and registry checks in accordance with state law to determine whether any of them are "ineligible persons," and therefore, excluded from participation in the Medicare or Medicaid programs. At minimum, registry and exclusion checks must include the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, Social Security Death Master File, HHS-OIG List of Excluded Individuals and Entities (LEIE), System for Award Management (SAM), and the Tennessee Terminated Providers List.

The screenings should be conducted prior to hiring employees or contracting with individuals and entities, and every month following. Providers are also required to have employees and contractors disclose if they're ineligible persons prior to providing any services on behalf of the provider.

If you have questions, please refer to the **Provider Networks - Federal Exclusion Screening Requirement** section of the **BlueCross BlueShield of Tennessee** and **BlueCare Tennessee Provider Administration Manuals**.

HEDIS® Measurement Year 2024 Medical Record Requests to Begin Soon

Each year, we're required to report Healthcare Effectiveness Data and Information Set (HEDIS) measures to maintain National Committee for Quality Assurance (NCQA) accreditation. NCQA uses these measures to determine whether members received the care and screenings they needed, and if the care improved their health.

Soon, you'll receive a request for medical records related to prevention and screenings, diabetes care, cardiovascular conditions, prenatal/postpartum care, medication management and well-child visits.

Note: BlueCross and BlueCare Tennessee providers are required to submit copies of requested medical records, and it's the provider's contractual responsibility to ensure the records requested are provided. If you use a copy service or vendor, please alert them to respond promptly to record requests.

Please call us at **(423) 535-3187** if you need help using any of these methods to submit your records:

- Remote access into your electronic medical records
- Secure email
- Fax
- On-site collection
- Our web-based portal

HEDIS is a registered trademark of NCQA.

E/M Overcode Education

Evaluation and Management (E/M) coding is an area the Centers for Medicare & Medicaid Services (CMS) has identified as having significant error rates. Both CMS and the Office of Inspector General (OIG) have documented that E/M services are among the most likely services to be incorrectly coded, resulting in improper payments to practitioners. The OIG has also recommended that payers continue to help educate practitioners on coding and documentation for E/M services, and to develop programs to review E/M services reported by high-coding practitioners.

E/M services are visits performed by physicians and non-physician practitioners to assess and manage a patient's health. Providers should report E/M services in accordance with the American Medical Association's (AMA's) CPT® Manual E/M documentation criteria and CMS guidelines for reporting E/M service codes. Complete medical record documentation is the foundation of every patient's health record and can significantly affect claim coding and adjudication.

Accurate coding translates clinical documentation into uniform diagnostic and procedural data sets and provides the details of the services reported and rendered to the patient. Each E/M service provided should be carefully documented according to CMS guidelines, "Documentation Guidelines for Evaluation and Management."

To maintain correct coding, the implementation of the E/M Overcode program supports nationally recognized and accepted coding policies and practices. The program will evaluate the appropriateness of high-level E/M service levels to ensure consistency. Based on the outcome of this evaluation, the reimbursement may be adjusted.

AMA CPT's E/M Guidelines for Office and Outpatient Services

E/M CMS coding guideline changes were effective Jan. 1, 2021, and these changes only apply to E/M services for office and outpatient services (99202-99215). All other E/M services should follow newly updated guidelines per the 2023 and 2024 updates from CMS and AMA.

Overview of E/M Overcode Program

- Evaluates and reviews only high-level office and outpatient E/M services based upon diagnostic information that appears on the claim and/or other claim data relevant to the same episode of care.
- Identifies outlier providers who consistently overcode E/M services.
- Applies the relevant E/M policy and recoding of the claim line to the corrected E/M level of service based on the intensity of the diagnostic, claim and patient history data.
- Note, the E/M will never be leveled lower than a level 3 and will only be applied to those claims from providers identified as outliers.
- Allows appropriate reimbursement prior to payment for the highest E/M service code level for which the criteria are satisfied based on our comparative peer risk adjustment process.

Appeals:

If a provider disagrees with a determination, they have the right to file an appeal in accordance to the Provider Administration Manual guidelines. The appeal should be submitted with the medical record documenting the details of the E/M service. The medical record will be reviewed to assess the intensity of service and complexity of medical decision-making for the E/M services provided.

- According to the CMS guidelines, "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT® code." The documentation in the medical record should support the CPT® and ICD codes reported on the health insurance claim form.
- Careful documentation and coding of services rendered by following CMS and AMA guidelines is essential. More information is available in the CMS Evaluation and Management Services Guide, found on their website.

Note: The information in this article doesn't apply to TennCare*Select*.

New Medical Record Requirement for Quality Care Rewards (QCR) Application

Effective **Jan. 1, 2025**, providers are required to upload supporting documentation from patient medical records to the QCR application in Availity® when attesting to the Hemoglobin A1c Control for Patients With Diabetes (HBD) <8% (CDC_HBA1C8) and Eye Exam for Patients With Diabetes (EED) measures. Uploading this documentation helps make sure patient records supporting attestations are readily available in the QCR application when we review attestations later.

Medical record upload for the Cervical Cancer Screening (CCS), Kidney Health Evaluation for Patients With Diabetes (KED) and Breast Cancer Screening (BCS-E) measures is being considered for a **March 1, 2025**, release. We'll provide more information once this release date has been confirmed. We'll be applying the same requirement to other HEDIS measures in the future, and we'll let you know when that change is coming.

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

Commercial

This information applies to Blue Network P℠, Blue Network S℠, Blue Network L℠ and Blue Network E℠ unless specifically identified below.

Helping Patients With High Blood Pressure

High blood pressure is a serious condition. You can help patients manage it by educating them about the risks associated with high blood pressure as well as the benefits of a healthy lifestyle, such as eating well, exercising and reducing salt.

Regular monitoring is key. Encourage patients to check their blood pressure at home and have regular check-ups. Digital tools can help track readings and remind patients about medications.

Medication adherence is crucial. Explain the importance of taking medications as prescribed and address any concerns. Simplifying medication routines can help.

HEDIS Measure: Controlling High Blood Pressure (CBP)

The CBP measure is defined as the percentage of patients 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled as defined by the most recent documenting reading of a systolic level of 139 or less and a diastolic level of 89 or less during the measurement year.

Click here to view more details about this measure in our Quality Care Measures & Comprehensive Program Information Guide.

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 will be 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**).

New High-Tech Imaging Prior Authorization Vendor

Cohere Health is now managing 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 on Availity.

Prior Authorization Letters Available in Availity

Beginning **March 1, 2025**, we'll no longer fax approval letters. Instead, you can 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 letters.

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

Understanding the Financial Responsibility Form and Prior Authorizations

Sometimes our members choose to pay for services their plan doesn't cover. 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 a non-covered 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 if they have benefits available under their plan.

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

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

Effective **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 is still part of the overall Federal Employees Health Benefits program, it's a separate plan from those offered to other federal employees in the program.

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

If you have questions, call PSHB at **1-866-780-7742**.

Commercial and BlueCare Tennessee

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

Peer-to-Peer Requests

You can now submit Peer-to-Peer requests for Commercial and BlueCare℠/TennCare*Select* members in Availity:

1. Log in to Availity.
2. Click on **Payer Spaces** and select the BlueCross BlueShield of Tennessee logo.
3. Select the **Authorization Submission/ Review** application.
4. Go to the **Auth Inquiry/Clinical Update** drop-down arrow then select **BCBST** to search for the existing authorization.
5. Select **Peer-to-Peer Review** from the **Service Information, Note Type** drop-down list.

A Peer-to-Peer request gives providers the opportunity to speak directly with a Medical Director and provide clinical information to dispute an adverse determination. Providers will be required to give two dates and times they're available to speak with the Medical Director. Peer-to-Peer requests can be scheduled Monday through Friday, excluding holidays.

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

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

BlueCare Tennessee

*This information applies to BlueCare℠, TennCare*Select* and CoverKids plans unless specifically identified below.*

Process Reminder: Requirements for Provider Subcontracting

Providers and vendors caring for members with BlueCare, TennCare*Select* and CoverKids coverage may not subcontract any part of covered services without written agreement from BlueCare Tennessee. Without prior agreement, we may deny claims for services provided by a subcontractor, and previous payment may be subject to recoupment.

To request approval for all provider/vendor subcontracts, providers in our networks and BlueCare Tennessee vendors must submit the **BlueCare Tennessee Provider/Vendor Subcontracting Form**. Providers must also complete the **Exhibit for Subcontractors Compliance with Terms of BlueCare Tennessee Provider Agreement**. You can find both documents on the **Documents and Forms page** of **bluecare.bcbst.com/providers**. Select **Administrative Information**, then choose the applicable form from the **Office Administration** drop-down menu.

Our network providers should send completed forms to **TennCare_Provider_Subcontracts@bcbst.com**, while our BlueCare Tennessee vendors should send completed forms to **Vendor_Relations_GM@bcbst.com**.

All provider and vendor subcontractors must also meet these requirements:

- All employees and subcontractors supporting the BlueCare Tennessee contract must complete **Deficit Reduction Act/Fraud, Waste and Abuse Training**.
- Records of services provided by subcontractors must be kept for at least 10 years after the agreement with BlueCare Tennessee expires, unless otherwise noted in the vendor contract.
- Subcontractors must verify that employees aren't listed on the **Office of the Inspector General List of Excluded Individuals and Entities**, **Social Security Death Master File** or the **System for Award Management** databases before hiring and every month during employment.

In the event a provider or vendor is terminating a contract with a BlueCare Tennessee-approved subcontractor, please complete the **BlueCare Tennessee Provider/Vendor Subcontracting Termination Form**, which is also located in the Office Administration section of our **Documents and Forms page**.

Our network providers should also send this completed form to **TennCare_Provider_Subcontracts@bcbst.com**, while our BlueCare Tennessee vendors should send the completed form to **Vendor_Relations_GM@bcbst.com**.

New High-Tech Imaging (HTI) Prior Authorization Vendor

Effective **Feb. 1, 2025**, Cohere Health, Inc., manages HTI prior authorizations.

Please continue to submit BlueCare℠ HTI requests directly to us through **Availity** or by calling **1-888-423-0131**. You can find a complete list of advanced imaging codes requiring prior authorization **here**.

This update is for BlueCare members only. TennCare*Select* and CoverKids members don't require prior authorization for HTI services if the care is performed by an in-network provider. If you have questions about using Availity, please call **(423) 535-5717**, **option 2**, or contact your **eBusiness Regional Marketing Consultant**.

Modifier JG Discontinued From 340B Drug Pricing Program

CMS recently issued updated guidance for the use of 340B program modifiers. For dates of service starting **Jan. 1, 2025**, the TB modifier will replace the JG modifier for all organizations and providers who participate in the 340B program. Please make sure to use the TB modifier on related claims moving forward.

Talk to Your Patients About Smoking and Vaping

Smoking and vaping can seriously harm a person's health. It's important to talk to your patients about these dangers. Provide clear information about the risks and encourage your patients to quit. Offer support, resources and treatment like nicotine replacement therapy. Regular follow-ups and encouragement are also key.

February is American Heart Month, a perfect time to emphasize the importance of heart health. Discuss how quitting smoking and vaping can significantly reduce the risk of heart disease and improve overall cardiovascular health. Encourage your patients to adopt heart-healthy habits like eating well, exercising and managing stress.

Vaping, often perceived as safer than smoking, still poses significant health risks. The aerosol from e-cigarettes can contain harmful substances like nicotine, cancer-causing chemicals, heavy metals and tiny particles that can be inhaled deep into the lungs. Nicotine is highly addictive and can harm brain development in young adults, affecting attention, learning, mood and impulse control. Additionally, some flavorings used in e-cigarettes can cause serious lung disease.

By educating and supporting your patients, you can help them make healthier choices and improve their well-being.

References

Health Effects of Vaping | Smoking and Tobacco Use | CDC

Dental Health for Children and Teens

February is National Children's Dental Health Month, a time to remind patients about the importance of proper dental care and regular checkups.

Encourage your patients to schedule routine dental checkups every six months. All BlueCare and TennCare*Select* members get dental benefits through their plan. They can get dental care like cleanings, fillings and more at no cost to them.

Along with regular dental appointments, here are some tips to share with parents and guardians.

Babies and Toddlers

- Clean your baby's gums with a damp cloth.
- Once teeth show, clean them with a soft bristled toothbrush with a smear (the size of a grain of rice) of fluoride toothpaste.
- Do not put your baby to sleep with a bottle because it causes baby bottle tooth decay.
- Wean your child from pacifiers and the bottle between 9 and 12 months of age.
- Take your child to the dentist before their 1st birthday or after the first tooth shows.
- Brush your toddler's teeth twice a day. Use a smear of fluoride toothpaste (the size of a grain of rice) for children age 6 months to 2 years and a pea-sized amount of paste for children age 3 years to 6 years.

Young Children

- Make sure your child brushes their teeth twice a day with fluoride toothpaste and flosses once a day.
- Many early cavities start with white spots that turn brown. After your child brushes, examine their mouth. If you notice white spots or bleeding gums, go to your dentist.
- Change your child's toothbrush every three months.
- Ask your dentist about sealants for your child's teeth.
- Have your child drink tap water that contains fluoride.

Teens

- Keep an eye out to make sure your teen is maintaining good oral health habits.
- Buy sugar-free gum if your teen chews gum.
- Teens who play contact sports should wear a mouthguard.

Click here for TennCare's child dental health guide.

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**.

Your New Source for Division of TennCare Announcements

You can now 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 Plus Tennessee

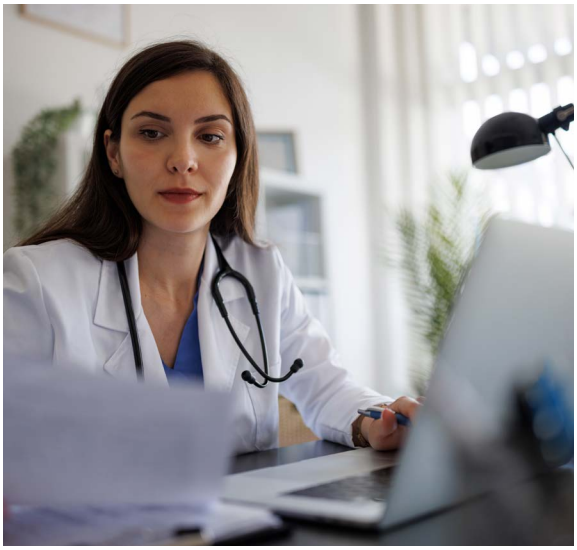
This information applies to our Medicare and Medicaid dual-eligible special needs plans unless specifically identified below.

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

Providers participating in BlueCare Plus Tennessee (HMO D-SNP)[SM] 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 Tennessee and BlueCare Plus Tennessee

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



Corrected Bills

When submitting a corrected paper bill, the original claim number issued to the claim being corrected must be filed in the Original Ref. No. portion of Block 22 on your CMS-1500 claim form or Block 64 on your CMS-1450 claim form. If this isn't done, your corrected claim will be denied XOC (original claim number submitted on the corrected bill is invalid or missing). When the claim is filed electronically the REF segment (claim information) in the 2300 Loop must include the original claim number issued to the claim being corrected.

For more information, please see the corrected bill guidelines in the **Provider Administration Manual** for your patient's plan.

Medicare Advantage

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

Tips for Notice of Medicare Non-Coverage Forms

Skilled nursing facilities are responsible for delivering a **Notice of Medicare Non-Coverage (NOMNC) form** when a member's covered service is ending. We've provided tips below to help ensure you're following CMS guidelines for this form.

- Identify the last day of covered service and discuss it with the patient, family or authorized representative.
- The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. **Note:** The two-day advance requirement is not a 48-hour requirement.
- The signed NOMNC must be received before an appeal can be requested.
- If the member is unable to sign and a representative is notified, a written statement is required and must include:
  - The representative's name and relationship
  - The date and time of the conversation (This is the same date on which the member's authorized representative is given notice)
  - The name of the facility staff who provided the information
  - Documentation that the representative was notified of:
    - Appeal rights and how to request an appeal by a Qualified Independent Contractor
    - The deadline to make an appeal
    - The Quality Improvement Organization phone number
- Providers must ensure the member or representative signs and dates the NOMNC and returns it to the plan by noon the following day.
- If the facility or health care provider doesn't deliver the detailed explanation of non-coverage to the member, the provider may be held financially liable for continued services until two days after the member receives a valid notice or until the effective date of the valid notice, whichever is later.
- Providers are required to fax a signed copy of the NOMNC to our Medicare Advantage Care Management Department at **1-888-535-5243**.

Acute Inpatient Stay Approvals

Acute inpatient stays are reviewed for medical necessity, and approval covers the entirety of the member's diagnosis-related group (DRG) stay. Approval also covers the DRG payment. Outlier payments may be subject to retrospective claims review. Note: Extended stay or concurrent reviews on admissions don't need to be submitted for admissions dates on or after **Oct. 16, 2024**.

Quality Care Rewards

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

Tennessee Health Care Innovation Initiative (THCII) Episodes of Care Gain-Share Payment Update

The 2023 Final Performance Reports for BlueCare Tennessee and Commercial were released in August 2024 to Quarterbacks participating in the Episodes of Care Program. We distributed payment in late December to Quarterbacks who achieved a gain-share payment reflected on the cover page of their 2023 Final Performance Reports.

If you have questions about your payment or report, please contact your Provider Network Manager.

THCII Episodes of Care Quarterly Report Release

New quarterly reports for Medicaid and Commercial Episodes of Care Quarterbacks will be available on **Feb. 20, 2025**. If you're a Quarterback who's having trouble accessing your quarterly report, please call **(423) 535-5717** and press **option 2** or email **eBusiness_Service@bcbst.com**.

Pharmacy

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

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™

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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–Friday, 8 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**.