of Tennessee

JANUARY 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

EFT, ERA and Enrollment Requests Must Be Submitted Through Change Healthcare

We're no longer accepting paper transactions for 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**. There 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 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 your 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 the March 1 release has been confirmed. We'll be applying the same requirement to other Healthcare Effectiveness Data and Information Set (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**.

Keep Your Practice Information Current

As providers leave your practice or group, it's important to notify BlueCross so we can keep our directories up to date. This helps ensure members are seeing providers who are in their network.

Please keep your CAQH information updated and make sure your address is correct on any data verification forms you receive from us.

Commercial

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

Find Upcoming Prior Authorization Changes

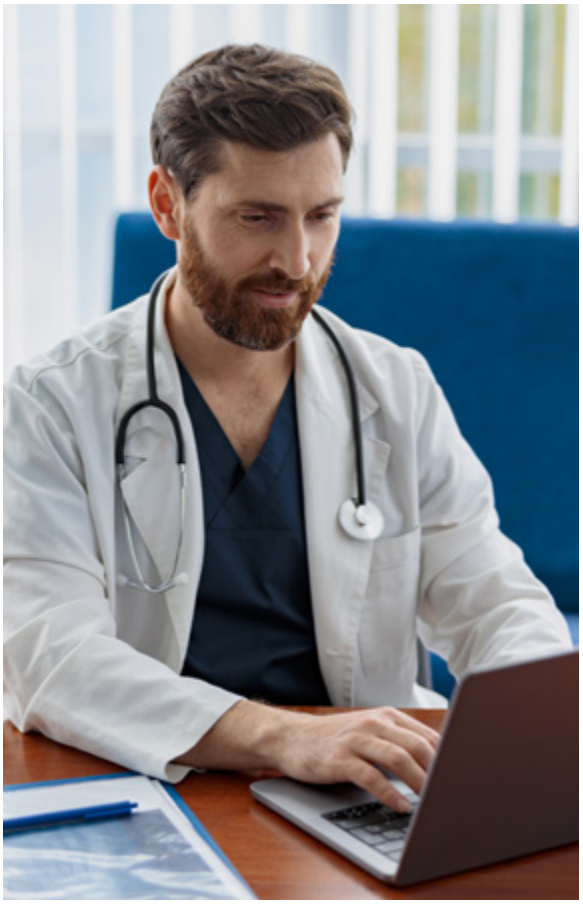
You can easily find the latest changes to prior authorizations under **Upcoming Prior Authorization Changes** in the News & Updates section of our Documents & Forms page. Prior authorization changes will be published at least 60 days before the effective date. If you have questions, please call us at **1-800-924-7141** and follow the prompts for providers **(option 1)**.

New High-Tech Imaging Prior Authorization Vendor

Starting **this month**, 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.



Prior Authorization Letters Available in Availity

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

Cervical Cancer Screenings

You can help your patients prevent cervical cancer by making sure they're up to date on their screenings.

Patients should have a cervical cancer screening per the guidelines below or more frequently based on their history and risk:

- **Age 21-64:** Cervical cytology during the measurement year or the two years prior
- **Age 30-64:** Cervical cytology and high-risk HPV testing or co-testing during the measurement year or the four years prior

OR

- **Age 30-64:** Cervical high-risk HPV testing during the measurement year of the four years prior

Note: Documentation of a hysterectomy alone doesn't exclude a patient. The documentation must show total hysterectomy, complete hysterectomy, vaginal hysterectomy, or that the cervix is surgically absent to show evidence that the cervix was removed and screening isn't needed.

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.

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 Blue Network P so there are no network changes. Additionally, benefits/coverage remains 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**.

BlueCare Tennessee

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

New High-Tech Imaging (HTI) Prior Authorization Vendor Coming Soon

Beginning **Feb. 1, 2025**, Cohere Health, Inc., will be managing HTI prior authorizations.

You'll 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, please call **(423) 535-5717, option 2**, or contact your **eBusiness Regional Marketing Consultant**.

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**.

Changes to Our Member Maternity Program Incentives

We've made some changes to our maternity program. Your patients with BlueCare Tennessee coverage still get an incentive for enrolling in the maternity program through the CareTN app and completing check-in surveys during their pregnancy. They also have an opportunity to earn an incentive for completing their postpartum visit between seven and 84 days after delivery.

Effective **Dec. 2, 2024**, here are the incentives they can expect to earn from the program:

- Enrolling in the maternity program through the CareTN app – $10
- Completing check-ins – $10 for 15 check-ins
- Completing a postpartum visit within 7-84 days after delivery – $25

We've retired the incentives for programs supporting those who quit smoking during pregnancy or whose baby needs extra care after birth.

We're committed to supporting our members during their maternal health journey and offer personalized assistance, resources and access to our care teams. For more information about how our maternity program can support your patients, please visit **bluecare.bcbst.com/get-care/pregnancy-support**. To learn more about payments our in-network obstetric providers can earn on top of regular reimbursement for maternity care, see the **Maternity Support** page of **bluecare.bcbst.com/providers**.

Consider Performing Well-Child and Sick Visits on the Same Day

Sometimes, kids and teens go several years between checkups, and an office visit for an illness, shots or prescription refill is the only chance you have to perform a well-child exam. That's why TennCare Kids screening guidelines allow reimbursement for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits performed at the same time as other services.

When patients visit your office for care, consider checking your patient roster in the Availity **Quality Care Rewards** application to see if they're up to date on preventive care. Then, perform well-child services during the appointment as appropriate.

Please note: Patients may schedule an appointment for a sports physical, but stand-alone sports physicals aren't covered services for BlueCare Tennessee members. However, by converting a sports physical appointment into a complete well-care visit, if appropriate, you can meet all requirements of the sports physical and be reimbursed for a covered service. For more information, please see our **EPSDT Provider Tool Kit**.

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

Enhancing Partnerships Between Providers, Foster Parents and Youth in Foster Care

Providers play an important role in supporting foster families and meeting children's medical and developmental needs. Below, we've included helpful tips to consider when working with foster parents and youth.

- **Help foster parents address health issues.** In addition to performing developmentally appropriate health screenings, providers can help foster parents recognize and manage emotional, physical and behavioral health concerns. Consider talking with foster parents about warning signs that children are having a difficult time processing their emotions or experiencing signs of past and present trauma, including:
  - Changes in eating and sleep habits
  - Separation anxiety
  - Mood fluctuations
  - Nightmares
  - Headaches
  - Stomach pain
  - Reacting strongly to situations or withdrawing
- **Connect foster families to community resources, like support groups, local organizations and early childhood intervention programs.** Keep in mind that grandparents and other family members caring for children in kinship care may need extra support, including financial assistance.
- **Model positive language about adoption, foster care and kinship care.** The American Academy of Pediatrics recommends providers help parents determine how and when to have developmentally appropriate conversations about the child's placement status, their birth parents or events in the past that may be difficult to discuss but help build trust.
- **Incorporate elements of trauma-informed care (TIC) into your approach to caring for children and teens in state custody.** Listen to children, teens and caregivers in active, nonjudgmental ways to help facilitate discussions about trauma. Additionally, when performing an exam or asking questions, consider explaining why you need to do so.
- **Brush up on cultural competency, an important component of TIC.** We've developed several documents about cultural competency you may find helpful:
  - **Cultural Competency Information**
  - **Non-Discrimination Compliance Training**

For more information about ways you can help support foster families and youth, please see these resources:

- **Pediatrics** – **Pediatrician Guidance in Supporting Families of Children Who Are Adopted, Fostered, or in Kinship Care | Pediatrics | American Academy of Pediatrics (aap.org)**
- **American Academy of Pediatrics** – **Trauma parenting insert (aap.org)**
- **American Academy of Pediatrics** – **Helping Foster and Adoptive Families Cope with Trauma**

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.

Make Sure You're Referring Patients to Providers in Our Networks

When referring your patients with BlueCare Tennessee coverage to a lab, specialist, facility or other provider, please make sure the provider is in our network. To find an in-network provider, use our **Find Care** tool or call the Provider Service line for your patient's plan:

- BlueCare – **1-800-468-9736**
- TennCareSelect – **1-800-276-1978**
- CoverKids – **1-800-924-7141**

Medicare Advantage

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

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 dated on or after Oct. 16, 2024.

Accurate Reporting for Medicare Advantage Wellness Codes

The start of a new year is a great time to encourage patients to schedule their Annual Wellness Visits (AWVs). These visits develop or update personalized prevention plans and perform a health risk assessment. We cover them once every 12 months at no cost to Medicare Advantage members.

When billing AWVs:

- Use codes G0438 or G0439.
- You can only bill G0438 or G0439 once in a 12-month period. G0438 is for the first AWV, and G0439 is for subsequent AWVs.
- Don't bill G0438 or G0439 within 12 months of a previous G0402 (IPPE) billing for the same patient.
- Report a diagnosis code when submitting AWV claims. You should choose diagnosis codes that are consistent with the patient's full exam.
- Include an update to the patient's written screening schedule based on the checklist for the next 5-10 years. You should also base this schedule on the patient's health risk assessment, health status and screening history, and age appropriate **preventive services**.

Click here for more information on AWVs.

Advance Care Planning (ACP) Reporting and Documentation

Be sure to document all ACP discussions and report the amount of time spent during the face-to-face encounter.

Accurate reporting is key. In your ACP documentation, you'll need to include:

- If the visit was voluntary
- An explanation of advance directives
- Who was present
- Time spent discussing ACP
- Any change in the patient's health status
- The patient's health care wishes if they become unable to make their own decisions

ACP services are time-based. Be sure to follow CPT® rules for minimum time requirements to report and bill for ACP services. If you perform another service concurrently, don't include the time spent on the concurrent service with the time-based service.

Don't bill any ACP discussion shorter than 15 minutes as ACP services. Instead, bill a different Evaluation and Management (E/M) service if you've met the requirements.

For more information about time-based billing and billing code descriptors, **click here**.

QCR Attestation and Assessment Deadline for 2024 Program Year

Provider Assessment Forms and measure attestations must be submitted by **Jan. 31** to be processed for the 2024 program year. Attestations and assessments completed by a non-clinical user role will show as **Pending** in your queues under the **Approval Queue** tile. Be sure to check both queues for pending attestations and assessments that need to be submitted by a clinical-level user role.

Remember, pending attestations and assessments that haven't been submitted by a clinical-level user role are automatically deleted after 90 days. Assessments with a date of service over 90 days can't be submitted. Once attestations and assessments have been submitted by a clinical-level user role, their status will update to **Submitted**. Once submitted attestations are processed, their status will update to **Reconciled**.

Please contact your Medicare Advantage Provider Quality Outreach Consultant for more information or questions about attestations and assessments.

Medicare Advantage 2025 Quality Program Measures

Effective **Jan. 1**, the following changes have been made to the quality measures included in the Medicare Advantage Quality+ Partnerships program:

- The **Polypharmacy – Multiple Anticholinergic Medications (Poly-ACH)** measure moved 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 replaced the **Hemoglobin A1c Control for Patients With Diabetes (HBD)** measure.
- The **Notification of Inpatient Admission (NIA)** and **Receipt of Discharge Information (RDI)** components have been removed from the scoring of the **Transitions of Care (TRC)** measure.
- The **Member Experience – CAHPS (BlueCross CMS Score/Mock Survey)** measure weight reduced from 4 to 2.
- The following measures have been 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.

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a new payment option designed to help your patients manage their out-of-pocket Medicare part D drug costs. This plan works with their drug coverage by spreading costs across the calendar year.

Who's eligible for the plan?

As of **Jan. 1, 2025**, anyone with a Medicare drug plan or a Medicare health plan with drug coverage can use this payment option. While all plans offer this option, your patients aren't required to use it. But there's no cost to join if they decide they want to participate.

How does it work?

Instead of paying for prescriptions at the pharmacy, the health or drug plan will bill them monthly.

This plan helps them manage their costs by spreading them out monthly. It doesn't lower their drug costs or save them money. Patients who expect a point-of-sale cost of $600 or more may benefit most from this option.

If your patient wants to participate in the plan, have them call us at the Member Service number on the back of their Member ID card.

Medicare Advantage and Dual Special Needs Plans

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

Step Therapy for Additional Medicare Part B Drugs

Effective **Jan. 1, 2025**, BlueAdvantage and BlueCare Plus Tennessee are requiring step therapy for additional Part B drugs. This change affects any patients who are new to therapy.

Key updates:

- Prior authorization, step therapy and CMS regulations are required for **Lanreotide Acetate**.
- Prior authorization is required, but step therapy is no longer required for **Somatuline Depot**.

For more information about our Part B step therapy updates, go to **provider.bcbst.com**. If you have questions, reach out to your Provider Service team.

Reminder: Restrictions for Opioids

The Centers for Medicare and Medicaid Services (CMS) changed their opioid prescribing guidelines effective **Jan. 1, 2019**, which apply to all Medicare Advantage plans.

These restrictions were implemented in 2019 and will continue through 2025:

- Pharmacies receive a safety edit when members are prescribed more than 90 MME* by two or more prescribers.
- Opioid-naïve members are limited to seven days for their initial fill.
- Members prescribed more than 200 MME by two or more prescribers will automatically reject, and the pharmacist can't override the rejection unless the member has an exempt diagnosis (cancer, sickle cell, etc.). If the member still requires more than 200 MME, the member, prescriber or representative can request a prior authorization.
- Concurrent use of long-acting opioids is restricted.
- Concurrent use of opioids and benzodiazepines is restricted.

*MME represents a drug's potency equivalent to morphine.

Note: These will reject at point-of-sale. In certain situations, the pharmacist at point-of-sale may be able to override these rejections. If not, a coverage determination will need to be requested if the member needs to continue the medication as prescribed.

You can find more information about these Medicare Part D Opioid Overutilization Policies here.

In addition to the above restrictions, we require prior authorization on all long-acting opioid medications. All opioids have a quantity limit restriction applied. You can find our drug lists and prior authorization criteria on the provider **documents and forms page**.

To request prior authorization or coverage determination for your patients, contact:

BlueAdvantage

Phone: **1-800-831-2583**

Fax: **(423) 591-9514**

BlueCare Plus

Phone: **1-800-299-1407**

Fax: **(423) 591-9514**

Peer-to-Peer (P2P) Review Process Updates

We've updated the P2P review process. Effective **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® No Longer on Our Preferred Formulary

Effective Jan. 1, 2025, Humira has been removed 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**.