



July 2016

# Blue<sup>+</sup>alert<sup>SM</sup>

## BlueCross BlueShield of Tennessee, Inc.

Applies to all lines of business unless stated otherwise

### Medical Policy Updates/Changes

The BlueCross BlueShield of Tennessee Medical Policy Manual will be updated to reflect the following new and revised policies. The full text of the policies listed below can be accessed at <http://www.bcbst.com/providers/mpm.shtml> under the “Upcoming Medical Policies” link.

#### Effective Aug. 13, 2016

- Hydroxyprogesterone Caproate for Injection Belinostat (Revision)
- Pancreas/Pancreas-Kidney /Pancreatic Islet Cell Transplantation (Revision)

#### Effective Aug. 20, 2016

- Belinostat (Revision)
- Cetuximab (Revision)
- Epidural Steroid Injections for Treatment of Back Pain (Revision)
- Obinutuzumab Belinostat (Revision)
- Panitumumab (Revision)
- Pneumatic Compression Pumps for Outpatient Use for Lymphedema, DVT Prophylaxis, and Venous Ulcers (New)
- Siltuximab (Revision)
- Temozolomide for Injection (Revision)
- Ustekinumab (Revision)

**Note:** These effective dates also apply to BlueCare /TennCareSelect pending state approval.

### Utilization Management (UM) Guideline Updates/Changes

BlueCross BlueShield of Tennessee’s website has been updated to reflect upcoming changes to select Management Guidelines. These upcoming changes to the UM Guidelines can be viewed on the [Utilization Management Web page](#).

#### Effective August 20, 2016

*The following Utilization Management Guideline related to Ambulatory Care will be archived:*

- Ambulatory/Day Surgery Criteria

*The following Utilization Management Guideline related to Ambulatory Care will be updated:*

- Cognitive Communication Disorders Rehabilitation

*The following Utilization Management Guideline related to Home Care will be updated:*

- Hyperemesis Gravidarum

*The following Utilization Management Guidelines related to Inpatient & Surgical Care will be updated:*

- Inpatient Goal Length of Stays Customized to Lower Range

**Note:** These effective dates also apply to BlueCare /TennCareSelect pending state approval.

### BlueAccess<sup>SM</sup> Improvements Coming Soon

Providers using the Quality Care Rewards application on BlueAccess to submit attestations and provider assessments, review quality metrics and monitor open gaps in care will soon see the following new features:

- Unified Provider View – Selecting a contract and provider will allow you to view all quality program data in the same session across all programs in which you are enrolled.
- Improved Navigation – A new tabbed layout allows for easy switching between member rosters and quality programs.
- New Filter Options – Typing in the search field on a member roster view allows for easy filtering by available data elements.
- Program and Attribution Information – Member rosters will include the reason for a patient attribution to a particular provider as well as all programs under which they are covered.
- Practice Notes – Users can enter free-form notes to track member details not otherwise documented in other data entry fields.

These changes will launch mid-to late third quarter. Resource materials and reference guides will be updated to guide users through the new application features. If you have questions about these changes, you may contact your Quality Care Rewards field staff, your Regional eBusiness Marketing Representative or the eBusiness Service Center.

**All Blue 2016 Workshops**

Join us for our annual state-wide All Blue workshops! Talk with BlueCross professionals who will share information about issues important to you and your practice. You can also visit our Resource Centers and take advantage of one-on-one discussions. Online registration begins soon!

<u>Region</u>	<u>Date</u>
Nashville	8/17
Chattanooga	8/31
Johnson City	9/14
Knoxville	9/15
Memphis	9/21
Jackson	9/22

**Reconsideration, Appeal and Binding Arbitration**

Providers who are not satisfied with the outcome of a claim or a prior authorization reconsideration request may submit a written appeal within 30 days of the reconsideration decision. If the dispute is regarding a Medical Management determination, the dispute must be submitted through the applicable Utilization Management appeals process, which varies by line of business.

No additional appeals options exist after the initial reconsideration and appeals steps have been completed. Providers who are still not satisfied

with the outcome of an appeal may request the dispute be submitted to binding arbitration. The provider is responsible for the costs associated with arbitration.

Information about the reconsideration, appeal and binding arbitration processes can be found in the Provider Dispute Resolution Procedure section of the provider administration manuals.

Additionally, TennCare Providers may file a request for independent review of disputed claims. See the [State of Tennessee website](#) for more information about the independent review process.

**Update: Enhancements Made to Discharge Date Process**

BlueCross BlueShield of Tennessee routinely seeks feedback from providers and hospital systems on how we can improve the way we work together to provide the most effective, efficient care for our members. Based on direct input from hospitals, we have made enhancements to the method by which we collect discharge dates.

Please note the following updated process for discharge dates for all lines of business:

- Each facility will produce one comprehensive list of discharges each day.
- All lines of business may be included on the list, as long as indicators for the appropriate line of business are also included.
- Coversheets should include facility name and NPI number.
- Discharges lists may be submitted two ways:
  - Email to [dcdates@bcbst.com](mailto:dcdates@bcbst.com)
  - Fax to (423) 591-9501

- Web submissions are also available for individual discharge entries.

Additional updates will be outlined in future issues of *BlueAlert*.

**The Power of Partnerships**

Fostering healthy, happy communities across the state is a fundamental element of BlueCross BlueShield of Tennessee’s mission.

Each year, the BlueCross Health Foundation and Community Trust partners with organizations in each of Tennessee’s 95 counties to improve access to health services, inspire individuals to get and stay active, enhance addiction counseling and treatment programs, supplement education, arts, culture and economic development programs.

Our charitable investments totaled \$14.8 million in 2015.

To learn more about the impact BlueCross is making in your community, visit our new, interactive partner map at [BetterTennessee.com/Partners](http://BetterTennessee.com/Partners). The map provides detailed information about BlueCross partners in each county, including the:

- Organizations we support in each of Tennessee’s 95 counties
- Categories of philanthropic work we support
- Grant amounts for each project
- Web and social media information for each organization

You can also read stories about the human impact of these programs in each issue of Better Tennessee magazine or online at [BetterTennessee.com](http://BetterTennessee.com).

## Changes Coming to Chiropractic Reimbursement

BlueCross BlueShield of Tennessee will soon send contract amendments to chiropractic providers in our Commercial networks. These amendments will outline changes being made to the reimbursement schedule for chiropractic services, which will be effective Oct. 1, 2016. More information will be communicated soon.

## Reminder: FREE Quality Training for Network Providers

BlueCross is offering a two-day class to promote health care quality. The training class is scheduled for Aug. 4 and 5, 2016, in the BlueCross BlueShield of Tennessee Community Room in Chattanooga, Tenn. The class is designed to help those planning to take the Certified Professional in Healthcare Quality (CPHQ) examination, and also delivers intermediate quality improvement content that can benefit anyone working in the field of health care quality. Get more information at: <http://www.bcbst.com/providers/Free-cphq-training-class.pdf>

The usual cost for this training is \$399; however, BlueCross is offering the class to its network providers at no cost. Space is limited, so please contact us soon to register. To qualify for the training you must meet the following criteria:

- Currently employed in a role related to quality improvement or management
- Currently employed by a BlueCross BlueShield of Tennessee network provider

Network providers will be limited to two participants per group/facility for the 2016 class. To register, email [tawanda\\_malone@bcbst.com](mailto:tawanda_malone@bcbst.com).

## Reminder: Up-to-Date Data Verification Forms Necessary to Improve Provider Directory Quality

Health plans are required by the federal government, states and other regulatory bodies to contact participating health care providers on a quarterly basis to review, update and confirm the accuracy of their information in provider directories.

If you receive a Data Verification Form, please verify your demographic information, sign and return the form promptly, even if all information on the form is accurate. If the Data Verification Form requires changes, please mark through the incorrect information and print the correct details in the space beside that field and fax to **(423) 535-3066** or email to **PNS\_GM@bcbst.com**. We ask that all providers respond promptly to update the information required for provider directories.

If you have any questions or need assistance with the Data Verification Form, please call the Provider Service Line† at **1-800-924-7141**. To help ensure your call is routed to the appropriate department, select the option "Provider Network Services" when prompted.

We are assessing more efficient means of electronic verification, including working with the Council for Affordable Quality Healthcare (CAQH) to help meet these requirements by using CAQH ProView™.

Throughout 2016 we will be implementing improvements to simplify the process of updating provider directories.

## Don't Get Caught in the Queue: Listen Carefully to Provider Service Line Prompts

If you find you're on hold with our Provider Service Line longer than usual, be sure you are listening carefully to the new menu prompts. We recently updated the prompts to help your call get routed to the appropriate area and help ensure you get the needed information quickly.

**Please note:** If you need to reach **Network Contracts or Credentialing** after dialing BlueCross' Provider Service line at 1-800-924-7141, choose "touchtone" (Option 1), then "provider" (Option 1 again). Then simply follow the prompt instructions to be routed to Network Contracts or Credentialing.

## Reminder: Physician Quality Information Application Available Until July 12, 2016

The Physician Quality Information Application on BlueAccess<sup>SM</sup> will be available for physician review and self-reporting until July 12, 2016. After July 12, provider ratings will be updated to reflect the self-reported submissions and the updated provider ratings will be included in our provider directories that are available on the company website for our members.

**Reminder: Prior Authorization Needed for Many Advanced Imaging Procedures**

As previously communicated, please remember that prior authorization for Commercial members is required for many advanced imaging services. Services that require prior authorization are listed on our website at [www.bcbst.com](http://www.bcbst.com).

Before submitting prior authorization requests for advanced imaging services, please verify member benefits and eligibility through BlueAccess, the secure area of our website, or by calling the Provider Service Line†.

Prior authorization requests can be submitted via fax to 1-888-693-3210 or through BlueAccess. When submitting requests online, the advanced imaging code must be the primary code.

**Reminder: Electronic Claims Submission**

Network providers (including oral surgeons) are required to submit all claims to BlueCross electronically. This includes secondary and corrected claims.

Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated. Please call [eBusiness Technical Support](http://www.bcbst.com)† if you need to discuss your office’s transition or any barriers that may prevent you from filing electronic claims.

**BlueCare Tennessee**

**This information applies to BlueCare, TennCareSelect and CoverKids plans, excluding dual-eligible BlueCare Plus (HMO SNP)<sup>SM</sup> unless stated otherwise**

**Claims for Pediatric Behavioral Health Services Require Proper CPT® Codes**

If your claims include services involving the Pediatric Behavioral Health Symptoms Checklist, make sure you’re using the proper codes. Developmental screenings should be coded using 96110, while 96127 should be used for behavioral/emotional assessments.

For more information on correct coding see the [Bright Futures and Preventive Medicine Coding Fact Sheet](#) available on the American Academy of Pediatrics website.

**TennCare Behavioral Health Guidelines to Change Later this Year**

Please be aware of changes that will take place later this year related to **Level 2 Mental Health Case Management** services and the implementation of Health Homes for qualifying individuals with behavioral health needs, as outlined as follows:

- The Bureau of TennCare will not allow reimbursement for Level 2 Mental Health Case Management services rendered after Sept. 30, 2016.
- Beginning Oct. 1, 2016, your patients who are receiving Level 2 Mental Health Case Management will transition to a Health Home (known as a Tennessee Health Link, or THL) for care

coordination activities. They will receive care coordination services from the THL to which they are assigned and attributed.

- Only TennCare designated THLs will be allowed to contract with MCOs for care coordination/THL activities.

You can find the updated medical necessity guidelines for [Level 2 and Assertive Community Treatment \(ACT\)/Program of Assertive Community Treatment \(PACT\)](#) in the Provider section of our website.

**Children with Special Needs Require TennCare Kids Services Too**

Children with special needs often receive extra care and visits to specialists or Primary Care Providers for specific reasons. While the reasons for the visits may not be for a check-up, children with special needs should also have TennCare Kids well-child check-ups every year.

You can find a [schedule of recommended visits](#) at the American Academy of Pediatrics website.

If you have questions about coding or billing, please see *Preventive Services Billed with Evaluation & Management Codes* in the **TennCare Kids** section of the [BlueCare Tennessee Provider Administration Manual](#).

**Reminder: TennCare Kids Billing and Documentation**

When a patient’s primary reason for a visit is a well-child TennCare Kids exam and a significant abnormality is discovered that will need additional evaluation and management, such as an

ear infection in a well-baby exam, the office visit code can be billed in addition to the preventive service. Modifier 25 should be attached to the evaluation and management office visit code. Conversely, when a patient presents with symptoms such as an ear infection and is due for a well-child exam and the complete well-child exam is performed, then both codes may be billed using the modifier 25 added to the office visit code. Remember, all seven components of the TennCare Kids exam must be completed and documented in the patient's medical record, including documentation of the nutritional assessment and physical activity portion of the exam.

**CMS to Hold Training for 2016 PERM Reviews**

The Centers for Medicare & Medicaid Services (CMS) reviews each state's Payment Error Rate Measurement (PERM) every three years and Tennessee is due for review in 2016. CMS will host two PERM provider education sessions in July to help providers who serve Medicaid and Children's Health Insurance Program (CHIP) communities understand their responsibilities during the PERM cycle.

The presentations will be repeated for each session. You will have the opportunity to ask questions live through the conference lines, webinar and the dedicated PERM Provider email address at: [PERMProviders@cms.hhs.gov](mailto:PERMProviders@cms.hhs.gov).

To learn more about these upcoming provider education sessions, please visit the [CMS website](#).

**Provider Education Session Schedule**

- Tuesday, July 19
- Wednesday, July 27

*Both sessions begin at 3 p.m. (ET).*

**Update: Quest Lab Exclusion List**

As of April 1, 2016, several Quest diagnostic codes were removed from the BlueCare Tennessee lab exclusion list due to underutilization. Upon further review however, it has been determined that a technical error caused several commonly used codes to be unnecessarily removed.

Of the 12 codes removed in the April 1 update, 7 have been returned to the exclusion list as of April 1, 2016. These codes include:

- 81000 – Urinalysis non-auto w/ scope
- 81002 – Urinalysis non-auto w/o scope
- 82270 – Occult blood feces
- 85060 – Blood smear
- 88177– Cytopathy, evaluation of fine needle aspirate
- 88329 – Pathology consultation during surgery
- 88332 – Pathology consultation during surgery; each additional tissue block

BlueCare Tennessee will adjust claims denied for these codes for dates of service April 1, 2016, to present. No further action is required on your part.

**Medicare Advantage**

**This information applies to BlueAdvantage (PPO)<sup>SM</sup> and BlueChoice (HMO)<sup>SM</sup> plans. BlueCare Plus (HMO SNP)<sup>SM</sup> is excluded unless stated otherwise.**

**Include Obesity and Malnutrition Codes When Appropriate**

With a rising number of patients having multiple chronic conditions, providers are using multiple ICD-10 codes to

accurately reflect the condition of the patient. Two common but diverse diagnosis codes often omitted from claims are obesity and malnutrition.

While the codes listed below don't include all codes associated with obesity and malnutrition, they do represent common conditions. When appropriate, please use these codes so the full medical condition of your patient is reflected:

**Overweight & Obesity**

Morbid Obesity due to excess calories: E66.01  
 Other Obesity due to excess calories: E66.09  
 Overweight: E66.3  
 Other Obesity: E66.8

**Malnutrition**

Mild protein calorie malnutrition (weight for age is 75 - 89 percent of standard): E44.1  
 Moderate protein calorie malnutrition (weight for age is 60 – 74 percent of standard): E44.0

**Limited by the Number of Diagnosis Codes You Can Report?**

Because we don't have the benefit of sitting with our members in an exam room, the claims we receive serve as a picture of that particular patient's visit with you. This helps us inform the Centers for Medicare & Medicaid Services (CMS) of the conditions of the Medicare beneficiaries you treat and allows us to maintain the full scope of benefits our members enjoy. It's important to accurately provide the specific diagnosis codes that represent the patient's health, including ongoing chronic conditions that may also impact that visit.

Recognizing that some practices have system limitations from either electronic medical records or claims

clearinghouse, we accept CPT® code 99080 for zero dollar claims providers can use to submit additional ICD-10 codes. **Note:** This code is not reimbursable and has no patient responsibility.

**Medicare Advantage Case Management Program**

The BlueCross Medicare Advantage Case Management program exists to help our sickest members, and those suffering from chronic conditions to effectively manage their illnesses and help them live the highest quality of life possible.

Our programs are designed to assist members with catastrophic health care needs, understanding or limited knowledge about their chronic conditions and those needing general assistance with medications, transportation or any other barriers to care.

All BlueCross Medicare Advantage members are eligible for case management. It is an opt-out program, meaning a member can choose to quit the program at any time. However, we encourage our members to participate in the program to receive the support they need to live happy and healthy lives.

You can help your patients by also encouraging them to participate. Refer them to case management by calling 1-800-611-3489 or faxing 1-800-727-0841.

**New, Simpler Provider Assessment Form**

An updated Provider Assessment Form (PAF) for Medicare Advantage

members and is [now available to download](#) on the [Quality Care Rewards website](#). The form has been shortened to six pages (instead of 11), and is in a fillable PDF format that allows you to complete it electronically or print and complete manually then fax to 1-877-922-2963. You will receive an incentive payment\* for submitting a completed form and a claim with CPT® code 99420, (for each complete PAF) based on the date of service as noted below:

- Jan. 1 – March 31: \$250
- April 1 – June 30: \$200
- July 1 – Sept. 31: \$175
- Oct. 1 – Dec. 31: \$150

\* Incentives are available for one completed PAF per member, per calendar year and will be paid to the provider who submits the first completed PAF for the member.



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

**Readmission Rates-Are they an Indicator to Quality Care?**

According to a report from the Agency for Healthcare Research and Quality (AHRQ), U.S. hospitals spent a total of \$41.3 billion between January and November 2011 to treat patients readmitted within 30 days of discharge (3.3 million readmits). The AHRQ also reports that in 2013, approximately two-thirds of U.S. hospitals were charged financial penalties by the Centers for Medicare & Medicaid Services (CMS) due to excessively high 30-day readmission rates for acute myocardial infarction, heart failure, and pneumonia.

**What can you do to improve this quality measure?**

- **Patient Education:** Patients discharged from the hospital with a clear understanding of after-hospital care instructions, including how to take their medicines and when to make follow-up appointments, are 30 percent less likely to be readmitted or to visit the emergency department than patients who lack this information, according to an AHRQ-funded study.
- **Follow-up Appointments:** A follow-up visit should be scheduled upon discharge from the hospital with a written reminder provided. A phone call is also helpful to remind patients to keep their appointment.

**Use Conservative Measures for Patients with Newly Diagnosed Low Back Pain**

Each year, 25-50 percent of American adults experience low back pain which makes it one of the most common reasons for seeking health care services. According to the National Committee for Quality Assurance (NCQA), low back pain improves within the first two weeks after onset for the majority of adults (unless there is obvious trauma or other contributing comorbidities). For adults ages 18-50 who have been diagnosed with uncomplicated low back pain, the National Committee for Quality Assurance (NCQA) recommends **waiting 28 days from the time of diagnosis before obtaining imaging studies unless the member at any time has a history of cancer, or in the previous 12 months has experienced trauma, abused IV drugs or has evidence of neurologic impairment.**

**Tips to ease symptoms include:**

- Anti-inflammatory medications
- Over-the-counter pain relievers
- Physical therapy
- Ice
- Rest

**New CPT® Category II Code Payment Opportunity for Prenatal/Postpartum Care**

Effective Aug. 1, 2016, BlueCare Tennessee and CoverKids will offer a new Prenatal/Postpartum Incentive Program that allows providers to receive a bonus incentive when submitting Category II code 0500F with the following specifications:

- Include the date of the last menstrual period (LMP) on your claim submission
- Send a completed Maternity Notification form via web or fax **and**
- Bill with the appropriate E&M code within 30 days of the visit that confirmed the pregnancy

BlueCare Tennessee and CoverKids will pay providers a bonus incentive when submitting Category II code 0503F with the following specifications:

- Include the date of delivery on your claim submission
- Postpartum visit must occur within 21-56 days after delivery
- Bill with the appropriate postpartum visit procedure code

Additionally, BlueCare Tennessee and CoverKids will reimburse separately for insertion of Intrauterine Device (IUD) (procedure code 58300) when performed at the time of delivery.

More information on this Incentive Program will be announced in the coming weeks.

**Reminder: In-Home Test Kits Available for Homebound Members**

Getting to the doctor’s office can be a challenge for some of your patients. That’s why BlueAdvantage offers in-home test kits for three of the most common annual screenings Medicare Advantage members need.

With a simple phone call to our independent health partner, Home Access, your BlueAdvantage, BlueChoice<sup>SM</sup> and BlueCare Plus members will receive an in-home test kit by mail for a:

- Immunochemical Fecal Occult Blood Test (iFOBT) for colorectal cancer
- Kidney function screening for diabetic patients
- HbA1c blood test for diabetic patients

The member then follows the detailed instructions on how to properly use and to mail the kit back to Home Access for testing. The written results are then sent to you and your patient. The screenings are at no cost to the patient and count toward your practice’s quality rewards incentive for attributed members.

Your patient can order a kit by contacting Home Access at 1-866-435-4372, Monday through Friday, 7 a.m. to 8 p.m. (ET).

**Patient Information Needed to Help Ensure Health After Inpatient Discharge**

To help ensure smooth transitions of care for our BlueAdvantage members, submit discharge information including the facility name, member name, date of birth, member ID, reference number

and discharge date by fax to (423) 591-9501 or email to [dcdates@bcbst.com](mailto:dcdates@bcbst.com). Timely and accurately communicating information is critical to effective care transitions and decreased readmissions.

Discharge dates play an integral role in claims processing and BlueCross’ quality assurance initiatives. After a BlueAdvantage member is discharged from your care, BlueCross care transition and case management staff contact the patient to identify post-discharge gaps, such as home care needs and required follow-up appointments. This process helps reduce patient readmission and improves overall care, but confirmation of discharge is required for this to take place.



**IMPORTANT REMINDER**



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

**Do you need help in another language? ¿Habla español y necesita ayuda con esta carta?**

Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCareSelect 1-800-263-5479. Llámenos gratis al CoverKids 1-888-325-8386

العربية (Arabic); Bosanski (Bosnian); كوردی – بادینانی (Kurdish-

Badinani); کوردی – سۆرانی (Kurdish-Sorani); Soomaali

(Somali); Người Việt (Vietnamese); Español (Spanish) call 1-800-758-1638.

Federal and state laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, disability or any other group protected by the civil rights laws. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim?

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**Archived editions of BlueAlert are available online at**  
<http://www.bcbst.com/providers/newsletters/index.page?>

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 Call 1-800-468-9698 for BlueCare, 1-888-325-8386 for CoverKids or 1-800-263-5479 for TennCareSelect to report discrimination compliance issues.

For TTY help call 771 and ask for 888-418-0008.

**†Provider Service lines**

*Featuring “Touchtone” or “Voice Activated” Responses*

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

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the “touchtone” option or just say **Network Contracts or Credentialing** when prompted, to easily update your information; **and**
- Update your Provider profile on the [CAQH Proview™](http://www.caqh.com) website.

**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 1-800-574-1003**  
 Monday–Friday, 8 a.m. to 6 pm. (ET)

<b>BlueCare</b>	<b>1-800-468-9736</b>
<b>TennCareSelect</b>	<b>1-800-276-1978</b>
<b>CoverKids</b>	<b>1-800-924-7141</b>
<b>CHOICES</b>	<b>1-888-747-8955</b>
<b>ECF CHOICES</b>	<b>1-888-747-8955</b>
<b>BlueCare Plus<sup>SM</sup></b>	<b>1-800-299-1407</b>
<b>BlueChoice<sup>SM</sup></b>	<b>1-866-781-3489</b>
<b>SelectCommunity</b>	<b>1-800-292-8196</b>

Available 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 1-800-841-7434**  
**BlueAdvantage Group 1-800-818-0962**  
 Monday–Friday, 8 a.m. to 6 p.m. (ET)

**eBusiness Technical Support**  
 Phone: Select Option 2 at **(423) 535-5717**  
 e-mail: [eBusiness\\_service@bcbst.com](mailto:eBusiness_service@bcbst.com)  
 Monday–Thursday, 8 a.m. to 6 p.m. (ET)  
 Friday, 9 a.m. to 6 p.m. (ET)

