BlueCross BlueShield of Tennessee, Inc.

This information 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 March 9, 2017

- Genetic and Protein Biomarkers for the Diagnosis and Cancer Risk Assessment of Prostate Cancer (Revision)
- Osteochondral Autografting (OCG) (Revision)
- Positron Emission Tomography (PET) for Cardiac Applications (New)
- Positron Emission Tomography (PET) for Miscellaneous Applications (Revision)

Note: These effective dates also apply to BlueCare Tennessee pending state approval.

2017 Medical Record Requests to Begin

BlueCross BlueShield of Tennessee and BlueCare Tennessee are required to report Healthcare Effectiveness Data and Information Set (HEDIS®) measures to maintain National Committee for Quality Assurance (NCQA) accreditation. Data is collected for Medicaid, Medicare Advantage, Commercial and CHIP/CoverKids products.

Medical record requests are sent to providers who show they treated the member or were assigned as the member’s primary care provider. We will be contacting you soon for medical records related to prevention and screening, diabetes care, cardiovascular conditions, prenatal/postpartum care, medication management and well child visits.

You may be asked to provide records related to a certain condition. Even if you did not specifically treat the member for that condition, you may be able to...
provide valuable information on the member’s health – such as blood pressure or medications. Please provide as much of the requested information as possible.

We will work with you to arrange the most appropriate method for obtaining medical record information, which may include scheduling onsite collection in your office or arranging delivery of records. Oversight audits of our medical record abstraction methodology require that we scan pertinent elements of member charts. If you use a copy service, please ask them to respond promptly to record requests.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows Covered Entities (such as practitioners and their practices) to disclose protected health information (PHI) to another Covered Entity (such as BlueCross and BlueCare Tennessee) without patient authorization as long as both parties have a relationship with the patient and the PHI pertains to that relationship for the purposes of treatment, payment, and health care operations. Additionally, all nurses reviewing charts on behalf of BlueCross and BlueCare Tennessee have signed a HIPAA-compliant confidentiality agreement.

Emergency Preparedness Requirements Set by CMS

The Centers for Medicare & Medicaid Services (CMS) established regulations requiring national emergency preparedness for Medicare and Medicaid participating providers and suppliers to adequately plan for both natural and man-made disasters, and coordinate with federal, state, tribal, regional and local emergency preparedness systems. These requirements were mandated Nov. 15, 2016, and must be implemented by Nov. 15, 2017. Click here to view the Federal Register Rules and Regulations related to this requirement.

The regulation addresses three key essentials that are necessary for maintaining access to health care services during emergencies, safeguarding human resources, maintaining business continuity, and protecting physical resources. The three key elements are:

2. Policies and Procedures – Develop and implement documents that support the successful execution of the emergency plan and risks identified during the risk assessment process.
3. Communication Plan – Develop and implement a system to contact appropriate staff, patients’ treating physicians, and other necessary persons in a timely manner to help ensure continuation of patient care functions throughout the facilities and to ensure that these functions are carried out in a safe and effective manner.

Additionally, facilities must:

- Develop and maintain an emergency preparedness training program.
- Offer annual training to their staff.
- Conduct drills and exercises to test the emergency plan.

Reminder: Verify Member Benefits and Eligibility Online

Member benefits often change at the turn of the new year, just like the calendar. The new year may bring new ID numbers for our subscribers and their families. Be sure to log into BlueAccessSM to obtain current eligibility and benefit details for your patients. These benefit details include information about copays, deductibles, coinsurance and benefit limitations. Most member ID cards are listed in the subscriber’s name. Looking up the member ID number in BlueAccess will list all members covered by the subscriber. Please contact your eBusiness Marketing Consultant for more information.

Reminder: New Opioid Prescription Policy Began January 1

BlueCross continues to address the growing national effort toward more appropriate use of opioids. Beginning Jan. 1, 2017, all members covered by BlueCross plans must have prior authorization (PA) for long-acting opioid drugs. Additionally, new quantity limits for all opioids are now in place.
Opioid Prescription Policy Changes
Effective Jan. 1, 2017

- Applies to your patients with BlueCross commercial, BlueAdvantage (PPO)SM, BlueChoice (HMO)SM and BlueCare Plus (HMO SNP)SM plans
- Prior authorization required for all long-acting opioid prescriptions
- Quantity limits for both short-acting and long-acting opioids prescriptions
- The combined morphine equivalent dose (MEqD) of all prescriptions cannot exceed 200mg/day

Note – Opioid treatment for members in hospice care or undergoing cancer treatment will receive approval, but still require a prior authorization request.

To view the entire policy on the Use of Opioids in Control of Chronic Pain, visit our website at http://www.bcbst.com/mpmanual/!SSL!/WebHelp/mpmprov.htm and select Administrative Services.

To Obtain Prior Authorization
- For your patients with BlueCross commercial plans, call 1-877-916-2271 or fax your request to 1-877-328-9799.
- For your patients who are covered by BlueAdvantage, BlueChoice or BlueCare Plus plans, call 1-844-648-9628 or fax your request to 1-877-328-9799.

Please remember, ALL patients must have a PA for their long-acting opioids.

Reminder: Understanding Member Rights and Responsibilities

We periodically remind members of the rights and responsibilities they have when they carry a BlueCross BlueShield of Tennessee or BlueCare Tennessee member ID card. These reminders are intended to make it easier for members to access quality medical care and to attain services. They also help members understand what they should expect from you, and what you expect of them.

Member rights and responsibilities are outlined in both the BlueCross BlueShield of Tennessee and BlueCare Tennessee provider administration manuals, which are available online at https://www.bcbst.com/providers/manuals.page.

Reminder: Credentialing Required for Nurse Practitioners and Physician Assistants

BlueCross requires all nurse practitioners and physician assistants to complete the credentialing and contracting process before providing services to our members. Beginning Jan. 1, 2017, nurse practitioners and physician assistants must be credentialed and contracted, either individually or as part of an existing physician group providing services to BlueCross members. Begin the credentialing process by completing the online Provider Enrollment Form.

Reminder: Obstetric Anesthesia Must Be Billed on Single Claim Form

Obstetric anesthesia for a planned vaginal delivery (01967) that ends in a C-Section delivery (01968) is to be billed on a single claim form using the date of delivery as the date of service. Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code on a separate claim. Add-on codes submitted with no primary code or a different date of service result in rejection and non-payment of the add-on code. In those cases with obstetrical anesthesia for the planned vaginal delivery beginning on one day and the actual caesarean delivery on the following day, dates of service for both codes should have the same “from and through” date, i.e. from beginning of anesthesia through to the completion.

Obstetric anesthesia services involving more than one provider (e.g. two physicians or two CRNA’s) for the same episode are to be submitted on a single claim, under one NPI, with the date of delivery as the date of service. Separate claims for multiple providers will result in denial for the add-on code.
BlueCare Tennessee

This information applies to BlueCare℠ and TennCareSelect plans, excluding CoverKids℠ and dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise.

Latest TennCare℠ PDL Includes Changes for Anti-Migraine Drugs and Ophthalmic Agents

The latest release of the TennCare Preferred Drug List (PDL) includes changes that may affect some of the medicines your patients take. Some of the most notable changes are related to Anti-Migraine: 5-HT1 Receptor Agonists, Hereditary Tyrosinemia Agents and Ophthalmic Immunomodulators.

In addition, some agents were removed from the list of branded agents classified as generics.

Click here for the most current PDL.
Click here for the notice of PDL changes effective Jan. 1, 2017.

Document Any Refusal to Vaccinate

Each parent or patient has the right to refuse recommended vaccines. If the parent or patient decides not to get recommended immunizations, their decision must be documented in the patient’s medical record. Resources for documenting the refusal are available on the American Academy of Pediatrics website. Additionally, the Centers for Disease Control and Prevention website has conversation tools to help talk with parents and patients about the importance of immunizations and the importance of preventive care.

BEHIP II Training Now Available

BlueCare Tennessee is proud to sponsor Behaviorally Effective Healthcare in Pediatrics (BEHIP) training along with the Tennessee Chapter of the American Academy of Pediatrics and Vanderbilt University School of Medicine.

Providers can take advantage of free training modules online, and earn 2.5 AMA PRA Category Credits℠ per completed module. Most courses take as little as an hour to complete.

Topics this training session includes:

- Trauma and early brain development
- Trauma competent care principals in a primary care setting
- Psychopharmacology
- Motivational interviewing
- Working with children and families in the child welfare system

This is the second part of training for an ongoing program that equips providers to improve diagnoses and care for patients with behavioral health conditions. To date, hundreds of providers across the state have already used this free resource.

To learn more about BEHIP II training, please contact TNAAP Training Coordinator Heather Smith at heather.smith@tnaap.org.

Your Timely Response Is Needed for Medical Records Requests

Often medical information or records are needed to process member claims, to determine reimbursement levels for certain procedures and for audits/reviews by the Bureau of TennCare. To reduce delays in claims processing, it is important that providers respond to these requests as quickly as possible.

Please note the following guidelines regarding medical record requests:

- Submit the request letter as the first page of your medical record.
- Fax the requested information to the number listed in the letter.
- Submit only the requested information.

Copies of the claim are not required. If claim copies are included, please attach behind the medical record.

Population Health Is Available for Eligible CoverKids℠ Patients

We can partner with you to help eligible CoverKids patients with certain conditions that need special care, including programs for tobacco cessation, weight management and transplant management. To refer a patient to the program, please complete a CoverKids Population Health Form and submit by email to DMScreeners_GM2@bcbst.com or by fax to 1-800-421-2885.
New Process for Submitting Population Health IEPs for CoverKids Members

Eligible CoverKids patients now have access to Population Health Individual Education Plan (IEP) services. To submit a request for your patient, please fax the IEP along with the Parental Authorization Release Form to 1-800-851-2491.

Reminder: Seven Required Components of a TennCare Kids Checkup

According to evidence-based guidance from the American Academy of Pediatrics, all seven components of a TennCare Kids physical exam must be performed and documented in the patient’s medical record. The date of the exam and documentation of the nutritional assessment and physical activity portion of the exam must be included. If the child is uncooperative or the examination was deferred or refused, be sure to include this information in the medical record.

1. Comprehensive Health (Physical and Mental) and Developmental History
   • Initial and Interval History
   • Developmental/Behavioral Assessment
2. Comprehensive Unclothed Physical Exam
3. Vision Screening
4. Hearing Screening
5. Laboratory Tests
6. Immunizations
7. Health Education/Anticipatory Guidance

Helpful services and required medical record documentation criteria for the TennCare Kids exam are available on the Tennessee Chapter of the American Academy of Pediatrics website.

Medicare Advantage

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

Code Changes for Drugs Requiring Prior Authorization

As of Jan. 1, 2017, code changes are effective for specialty drugs requiring prior authorization for Medicare Advantage patients. The 2017 Medicare Advantage Specialty Pharmacy List is available online.

BlueCross has partnered with Magellan Rx ManagementSM to facilitate the prior authorization process for provider-administered specialty medications.

Because more detailed information is being requested through the prior authorization process, and because we want to help ensure you get the fastest response possible, authorization requests must be submitted online through BlueAccess or by calling 1-800-841-7434. Prior authorization requests for specialty medications are no longer being accepted by fax.
New CPT® Code for Submitting a Provider Assessment Form in 2017

In 2017, physicians are again eligible to receive payments for completing and submitting a Provider Assessment Form (PAF) for their attributed BlueAdvantage℠ and BlueChoice℠ members.

Note: The CPT® code that should be used to file a PAF claim is changing. The new code, as of Jan. 1, 2017, is 96160. CPT® code 99420 is no longer valid.

BlueAdvantage will continue to reimburse the service as E/M Code 96160 with a maximum allowable charge of:

- $250 for dates of service between Jan. 1 and March 31, 2017
- $200 for dates of service between April 1 and June 30, 2017
- $175 for dates of service between July 1 and Sept. 30, 2017
- $150 for dates of service between Oct. 1 and Dec. 31, 2017

To receive reimbursement, you must complete the form and submit electronically via BlueAccess or complete the writable Provider Assessment Form and submit via fax to 1-877-922-2963. The form should also be included in your patient’s chart as part of his or her permanent record.

Annual Wellness Exam Must Be Documented for Members to Earn Incentives

An annual wellness exam is an important first step to a healthy 2017. Patients who complete a wellness exam at the beginning of the year are more likely to continue with important tests and screenings throughout the year. They are also eligible to earn a reward for completing the exam. You can help your BlueCross Medicare Advantage patients earn additional rewards for their healthy living by scheduling a check-up early.

In 2017, members will need to take the following steps to be eligible for rewards:

1. “Opt in” to the rewards program with OnLife Health, our new rewards partner. Each member received a welcome kit in January detailing opt-in instructions.
2. Get an annual wellness exam. Claims must be on file for members to receive additional rewards* in 2017 for other needed screenings. Annual wellness exams should be filed with 96160, 99385, 99386, 99387, 99395, 99396, 99397, GO402, GO438, GO439, plus appropriate E/M codes.

Members earn 15 wellness points for completing their exam in 2017; however, they can also earn 10 bonus points if completed prior to Oct. 1, 2017.

*Additional information about specific screenings eligible for rewards will be available soon. This program aligns with the annual STAR rating and quality bonus for providers.

High-Tech Imaging Authorization Vendor Changes Effective Jan. 1, 2017

BlueCross BlueShield of Tennessee has partnered with Magellan Healthcare National Imaging Associates (NIA) radiology benefit management program to perform authorization review for non-emergent outpatient advanced imaging and cardiac imaging services for BlueCross’ Medicare Advantage and BlueCare Plus℠ members. Emergency room, observation and inpatient imaging procedures do not require prior authorization. If an urgent/emergent clinical situation exists outside of a hospital emergency room, please call 1-888-258-3864.

Procedures requiring prior authorization:

- CT/CTA
- CCTA
- MRI/MRA
- PET Scan
- Myocardial Perfusion Imaging
- Muga Scan
- Stress Echocardiogram

You may request prior authorization from Magellan by logging in to BlueAccess at www.bcbs.com or by calling 1-888-258-3864. Magellan does not accept authorization requests via fax.
Medicare Part D Prescriber Enrollment Requirement

The Centers for Medicare & Medicaid Services (CMS) will implement a multifaceted/phased approach to help ensure enforcement of the Part D Prescriber Enrollment requirement on Jan. 1, 2019, unless the health care provider formally “opts out”. This requirement impacts most providers (e.g., dentists, physicians, psychiatrists, residents, nurse practitioners and physician assistants), including Medicare Advantage providers, who prescribe medications for patients with Part D plans.

Prescribers must be enrolled in an active status for their written prescriptions to be covered under the Medicare Part D benefit plan. CMS previously announced that enforcement of the prescriber enrollment requirement would begin Feb. 1, 2017, but has delayed the implementation requirement to minimize the impact on the beneficiary population and to help ensure beneficiaries have access to the care they need.

Note: CMS must also be notified by Jan. 1, 2019, if you choose to opt out of the program. By opting out you cannot receive reimbursement from traditional Medicare or a Medicare Advantage plan, either directly or indirectly (except for emergency and urgent care services).

To help your Medicare patients, please enroll in Medicare to bill and prescribe Part D benefits. There are no fees to complete the process. Enroll online or by mail.

- Fast-track the enrollment process online via the Medicare Provider Enrollment, Chain and Ownership System (PECOS).
- Enroll offline by completing the CMS-855O (paper) Enrollment Application and submitting to the appropriate Medicare Administrative Contractor (MAC).

For more information see the CMS How to Enroll page.

Coding Information for Compounded Bevacizumab (Avastin)

In November 2016, the Medicare Administrative Contractor (MAC) for the State of Tennessee retired its Local Coverage Determination (LCD) for intravitreal Avastin.

Beginning Feb. 1, 2017, compounded bevacizumab (Avastin) for the treatment of retinal diseases of the eye should be coded in the following manner: CPT® 67028, and HCPCS J7999, with a primary diagnosis supporting the retinal eye condition. Claims for compounded bevacizumab (Avastin) for intravitreal administration coded with J9035 will be denied.

The National Drug Code (NDC) for Avastin, when billed as compounded bevacizumab, does not require prior authorization. Avastin for other clinical conditions does require authorization through Magellan Rx.

Other intravitreal medications for the treatment of retinal diseases also require prior authorization.

Reminder: Right of Reimbursement and Recovery (Subrogation)

The Right of Reimbursement and Recovery (Subrogation) is a provision in the member’s health care benefit plan that permits the Medicare Advantage Part C (MA) plan to conditionally pay you when a third party causes the member’s condition. The MA plan follows Medicare policy where by law, 42 U.S.C. §1395y(b)(2) and § 1862(b)(2)(A)/Section and § 1862(b)(2)(A)(ii) of the Social Security Act, Medicare may not pay for a beneficiary’s medical expenses when payment “has been made or can reasonably be expected to be made under a workers’ compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance.”

According to 42 U.S.C. 1395y(b)(2)(B)(ii)/Section 1862(b)(2) (B)(ii) of the Act and 42 C.F.R. 411.24(e) & (g), the Centers for Medicare & Medicaid Services (CMS) may recover from a primary plan or any entity, including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer that has received a primary payment. Likewise, the MA plan sponsor may recover in the same manner as CMS.

Similar to Medicare, if responsibility for the medical expenses incurred is in dispute and other insurance will not pay promptly, the provider may bill the MA plan as the primary payer. If the item or service is reimbursable under MA and Medicare rules, the MA plan may pay conditionally on a case-by-case basis, and will be subject to later recovery if there is a subsequent settlement, judgment, award, or other payment. In situations such as this, the member may choose to hire an attorney to help them recover damages.
Reminder: Annual CAHPS Survey Includes Questions About Member Experiences With Physicians

The Centers for Medicare & Medicaid Services (CMS) conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey every year which contains several questions directly related to the member’s experience with their doctor. The specific questions include:

- In the last six months, when you needed care right away, how often did you get care as soon as you thought you needed?
- In the last six months, how often did your personal doctor explain things in a way that was easy to understand?
- In the last six months, how often was it easy to get an appointment with a specialist?

The responses CMS receives from our Medicare Advantage members become part of BlueCross’ network contracted physician’s annual STAR quality rating score.

For more information about the CAHPS survey, please see the Quality Care Rewards page on our website.

Reminder: Peer-to-Peer and Re-evaluation Process Changes

New guidance from the Centers for Medicare & Medicaid Services (CMS) will change some BlueCross provider peer-to-peer and re-evaluation processes. The following are changes that became effective Jan. 1, 2017:

- When insufficient clinical documentation exists to support an organizational determination, and after BlueCross has made three separate attempts to obtain clinical information from the requesting provider, a BlueCross medical director will contact the provider for the documentation. If the provider cannot be reached, we will follow up with a specific “intent to deny” fax. If the needed clinical information is not received within one business day, an adverse determination will be issued for insufficient clinical documentation. No additional peer-to-peer options will be available to the requesting provider. Documents submitted after the organizational determination will be treated as a member appeal (reconsideration) according to CMS regulations.

- When an adverse determination was rendered and there was sufficient clinical information, the requesting provider can ask for a peer-to-peer conversation or submit additional clinical documentation. Either will be treated as a member appeal if services have not yet been rendered. There will not be a re-evaluation process per CMS guidance.

- When requests are treated as member appeals, only the member and rendering provider have appeal rights. Everyone else needs to have an Appointment of Representative (AOR) form on file before the appeal can be processed. This includes third-party companies acting on behalf of a facility for adverse determinations appealed while the member is still in the hospital.

- Services rendered with no additional member financial responsibility will be processed as provider appeals. One peer-to-peer conversation and one level of provider appeal are permitted during this process, followed by binding arbitration. This process includes inpatient services with adverse determinations and the member was discharged from the hospital.
Reminder: CMS-2728-U03 Required Annually for Dialysis Clinic Claim Reimbursement

As of Jan. 1, 2017, initial dialysis clinic claims filed with Type of Bill 072X require annual submission of a completed CMS-2728-U03 form for each patient. Reimbursement will not be considered for dialysis clinic claims in a given calendar year, if a completed CMS-2728-U03 form is not on file with BlueCross. The initial and subsequent claims will be denied requesting the provider to submit the completed form.

You may fax the form to (423) 535-5498 or mail to:

BlueCross BlueShield of Tennessee
Attn: BlueAdvantage Revenue Reconciliation
1 Cameron Hill Circle, Suite 0002
Chattanooga, TN 37402-0002

Quality Care Rewards

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

Help Your Patients Take Control of Their Heart Health

Encouraging your patients to manage their blood pressure by checking it at home and keeping a journal may lead to better heart health. At-home monitoring can help your patients maintain their blood pressure within the following ranges:

- 18-59 Years of Age: <140/90
- 60-85 Years of Age: Diabetic: <140/90
- 60-85 Years of Age: non-Diabetic: <150/90

Decrease the Risk of a Second Heart Attack

A previous heart attack increases the risk of having a second. Beta-blockers are shown to lower the risk of having a second heart attack, and to help prevent sudden cardiac death. For patients that have recently experienced a heart attack, it is important to encourage them to take the prescribed beta-blocker medication for at least six months after their heart attack.

SilverSneakers® Benefit for BlueAdvantage and BlueChoice Members

BlueCross provides benefits to your BlueAdvantage and BlueChoice patients designed to keep them heart healthy. Talk to them about the importance of physical activity, and let them know about SilverSneakers, a free gym membership included with their BlueCross Medicare Advantage Health Plan. SilverSneakers has hundreds of participating locations across Tennessee.

Reminding your patients about the importance of physical activity, along with taking steps to make sure their blood pressure is under control, and keeping them adherent with their prescriptions for conditions like high cholesterol or hypertension, may help boost your quality scores and earn fee schedule bonuses from BlueCross.

Pharmacotherapy Management of COPD

Early diagnosis and aggressive treatment of Chronic Obstructive Pulmonary Disease (COPD) may improve a patient’s quality of life and lifespan.

Adequate control of COPD relies on the proper use of both short-acting and long-acting medications. The National Committee for Quality Assurance recommends that after a COPD exacerbation a patient be prescribed and dispensed a systemic corticosteroid within 14 days of discharge, as well as a bronchodilator within 30 days of discharge.

Tips to help increase COPD medication adherence:

- Incorporate prescriptions and medication instructions in discharge planning.
- Offer to “call in” prescriptions to your patient’s home pharmacy to make picking up their prescriptions more convenient and increase the likelihood for medication adherence.
- If the hospital has an in-house pharmacy, encourage your patients to fill prescriptions before leaving.
- Explore reasons for non-compliance and initiate Case Management if needed.
BlueCross BlueShield of Tennessee complies 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 TennCareSelect. For TTY help call 771 and ask for 888-418-0008.

*Changes will be included in the next provider administration manual update as applicable. Until then, please use this communication to update your provider administration manual.

Archived editions of BlueAlert are available online at [http://www.bcbst.com/providers/newsletters/index.page](http://www.bcbst.com/providers/newsletters/index.page)

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**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 press 1. Then, press 1 again and follow the prompts to reach Network Contracts or Credentialing to update your information; and
- Update your provider profile on the CAQH ProView™ website.

<table>
<thead>
<tr>
<th>Service Line</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td><strong>Commercial Service Lines</strong></td>
<td>1-800-924-7141</td>
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<tr>
<td>Monday-Friday, 8 a.m. to 6 p.m. (ET)</td>
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<tr>
<td><strong>Commercial UM</strong></td>
<td>1-800-924-7141</td>
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<tr>
<td>Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)</td>
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<tr>
<td><strong>Federal Employee Program</strong></td>
<td>1-800-574-1003</td>
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<td>Monday-Friday, 8 a.m. to 6 p.m. (ET)</td>
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<td><strong>BlueCare</strong></td>
<td>1-800-468-9736</td>
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<td><strong>TennCareSelect</strong></td>
<td>1-800-276-1978</td>
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<td><strong>CoverKids</strong></td>
<td>1-800-924-7141</td>
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<td><strong>CHOICES</strong></td>
<td>1-888-747-8955</td>
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<td><strong>ECF CHOICES</strong></td>
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<tr>
<td><strong>BlueCare Plus℠</strong></td>
<td>1-800-299-1407</td>
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<td><strong>BlueChoice℠</strong></td>
<td>1-866-781-3489</td>
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<tr>
<td><strong>SelectCommunity</strong></td>
<td>1-800-292-8196</td>
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<td>Available Monday-Friday, 8 a.m. to 6 p.m. (ET)</td>
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<td><strong>BlueCard</strong></td>
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<tr>
<td>Benefits &amp; Eligibility</td>
<td>1-800-676-2583</td>
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<tr>
<td>All other inquiries</td>
<td>1-800-705-0391</td>
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<td>Monday–Friday, 8 a.m. to 6 p.m. (ET)</td>
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<td><strong>BlueAdvantage</strong></td>
<td>1-800-841-7434</td>
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<tr>
<td><strong>BlueAdvantage Group</strong></td>
<td>1-800-818-0962</td>
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<td>Monday-Friday, 8 a.m. to 6 p.m. (ET)</td>
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<td><strong>eBusiness Technical Support</strong></td>
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<tr>
<td>Phone: Select Option 2 at</td>
<td>(423) 535-5717</td>
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<td>Email: <a href="mailto:eBusiness_service@bcbst.com">eBusiness_service@bcbst.com</a></td>
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<td>Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)</td>
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Be sure your CAQH ProView™ profile is kept up to date at all times. We depend on this vital information.