

# BlueAlert<sup>SM</sup>

## BlueCross BlueShield of Tennessee, Inc.

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

### Provider Stability Act Requires Us to Collect Your Contracting Email Address

For the last few months, we've been collecting contracting email addresses for the Provider Stability Act that goes into effect Jan. 1, 2019. The Provider Stability Act requires all Commercial Tennessee health plans to email you about activities impacting reimbursement, medical policies and fee schedules. It's important we have your updated information so we can reach you. If you haven't provided your contracting email address, please do so soon.

#### What You Need to Do

- Log in to [Availity](#)<sup>®</sup>.
  - If you haven't yet, [Register](#) for Availity access.
- Go to **Payer Spaces** at Availity.com.
- Select **Contact Preferences** to verify your preferences for BlueCross contracts.
- From the **Contract Details** screen, you'll need to confirm your contracting email address and **Opt In** for these communications.

To learn more, please see our step-by-step guide on the Provider Stability Act page at [bcbst.com/providers/psa](http://bcbst.com/providers/psa).

#### We Need Your Updated Mailing Address Too

If we can't reach you by email, we'll need to send communications by mail. If your mailing address isn't correct in Availity, please:

1. Download and follow the instructions on our [Provider Change Form](#).
2. Go to [CAQH ProView](#)<sup>®</sup> to make sure your information matches what you've sent to us.

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## Go to Availity to Check Eligibility and Benefits

All providers\* except dental are required to go to [Availity.com](https://www.availity.com) for eligibility and benefits status – not to our Provider Service Line. To check eligibility and benefit information, simply log in to Availity, click **Patient Registration** and then **Eligibility and Benefits Inquiry**.

If you make an inquiry and can't get the information you need, the system will give you a Fast Path ID to contact Provider Service. You must have a valid Fast Path ID for each patient inquiry.

For now, dental providers can continue to get eligibility and benefits status by phone. We'll notify you when you need to get this information through the Availity portal.

If you have questions, please contact your [eBusiness Regional Marketing Consultant](#). Thank you for using all of Availity's self-service features.

\*This also applies to outsource vendors acting on the provider's behalf.

## BlueCross Updating Opioid Prescription Coverage Policy Jan. 1 – UPDATE

BlueCross continues to explore ways to promote the appropriate use of opioids and keep members safe. These efforts include the changes to our formularies and opioid prescription policy listed below. The focus of these changes is not cost reduction, but rather to help our members and eventually all Tennesseans get the appropriate amount of opioids for their medical conditions.

### Effective Jan. 1, 2019, we'll make the following changes to coverage allowances for our Commercial (Blue Network P<sup>SM</sup>, Blue Network S<sup>SM</sup> and Blue Network M<sup>SM</sup>) and CoverKids members:

- Remove OxyContin from formulary and replace with abuse-deterrent drugs (i.e. Xtampza and Morphabond)
- Place stops on dangerous drug combinations (i.e. opioids/benzodiazepines).
- Reduce the morphine milligram equivalent (MME\*) allowed:
  - 120 MME cumulative total
  - Maximum allowed of 200 MME with a prior authorization
  - Note: Medicare Advantage still has maximum allowed of 200 MME
- Add controls for short-acting opioids:
  - Limit new prescriptions for short-acting opioids to seven days
  - Change look-back period for new prescriptions to 120 days
  - Require prior authorization on short-acting opioids prescribed for an extended period (more than 30-day supply in a 90-day period)

Please note that these changes won't effect members who are receiving treatment for certain conditions, so prior authorization requests for the following will receive auto-approval:

- Cancer
- Palliative Care
- Sickle Cell Disease
- End of Life Care

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

## 2019 Formulary Changes

Each year, we review our BlueCross formularies and make changes based on a drug's safety, effectiveness and affordability. Although many of these changes happen at the beginning of the year, they may occur at any time because of market changes such as:

- Release of new drugs to the market after FDA approval
- Removal of drugs from the market by the FDA
- Release of new generic drugs to the market

Please visit the following links to view the 2019 Formulary Changes listed below:

- [2019 Preferred Formulary Changes](#)
- [2019 CoverKids Formulary Changes](#)
- [2019 Essential Formulary Changes](#)

We've sent letters to our members whose medications are changing to non-formulary status Jan. 1, 2019. We won't send letters about every formulary change, so please remind your patients to check for changes at [bcbst.com](https://www.bcbst.com).

## Expired License Will Require New Provider Enrollment and Effective Date

Providers who participate in our networks are required to maintain a valid medical license. If a provider's license is revoked or expires, we must remove them from our network immediately to protect patients and the integrity of our network. Providers who want to return to the network must submit a new enrollment application. In these cases, network participation will not be retroactive. Providers will receive a new network effective date.

## Autoimmune Infusion Benefit Procedure Changes for Federal Employee Program Members

Starting Jan. 1, 2019, Federal Employee Program (FEP) benefit procedures will change for the autoimmune infusion drug Infliximab (brand names Remicade®, Inflectra® and Renflexis®). This drug is currently covered under the member's pharmacy or medical benefits. However, members who receive their first infusion on or after Jan. 1, 2019, will only receive the drug under the medical benefit. Members who have had autoimmune infusions covered by their pharmacy benefit before Jan. 1, will continue receiving this benefit. If members change FEP benefit plans (e.g., from Standard Option to Basic Option), the drug will be covered under medical benefits regardless of how they previously received it.

## New Coverage Option for Federal Employees

FEP members will have a third coverage option starting Jan. 1, 2019. In addition to Standard Option and Basic Option coverage, FEP Blue Focus<sup>SM</sup> gives federal employees, especially those just entering the workforce, an opportunity to choose a lower-cost quality health plan that best fits their needs. FEP Blue Focus members will pay just \$10 each for their first 10 primary and/or specialty care visits and will pay little or no cost for services that support good health. Read more about FEP Blue Focus here.

## Reminder: Resuming Payment Policy for the Technical Component of Anatomic Pathology Services Jan. 1, 2019

As mentioned in our August through November BlueAlert newsletters, we'll resume our regular payment policy for the technical component of anatomic pathology services furnished on and after Jan. 1, 2019.

To help further clarify our payment policy, we also sent contract amendments to all physicians and physician groups that contract with BlueCross, including pathologists and other specialists, in August 2018.

For additional details, please refer to the referenced newsletters or the Important Initiatives section of our [website](#). You can also contact your [BlueCross Network Manager](#).

## Coming Soon - Cite Guideline Transparency

We'll soon offer MCG Care Guidelines' Medicare Compliance Product. It was designed to incorporate Medicare's National Coverage Determinations (NCDs) into the MCG format, which will save time and improve documentation practices. MCG's Medicare Compliance Product is offered within the MCG payer software and Cite AutoAuth.



## All Blue Workshops 2019 Coming to a City Near You

Save the date for our annual All Blue Workshops. We're finalizing details, so watch for more information in upcoming BlueAlerts.

- **March 7, 2019 – Chattanooga**  
Embassy Suites Chattanooga  
2321 Lifestyle Way, Chattanooga, TN 37421
- **March 12, 2019 – Memphis**  
Holiday Inn University of Memphis  
330 Innovation Drive, Memphis, TN 38152
- **March 13, 2019 – Jackson**  
DoubleTree Jackson  
1770 Highway 45 Bypass, Jackson, TN 38305
- **March 18, 2019 – Nashville**  
Marriott Nashville Airport  
600 Marriott Drive, Nashville, TN 37214
- **April 16, 2019 – Kingsport**  
MeadowView Marriott  
1901 Meadowview Parkway,  
Kingsport, TN 37660
- **April 17, 2019 – Knoxville**  
Knoxville Convention Center  
701 Henley Street, Knoxville, TN 37902

## Billing Accuracy and Cost Control

As of Oct. 1, 2018, an itemized statement is required for all Commercial inpatient facility services that are reimbursed at a percent of charges (including services reimbursed through the BlueCard® Program). Please submit the itemized bill through the faxed paperwork (PWK) attachment process. If we don't receive the required documents, your claims may be denied or returned.

## Changes to Our Online Commercial Provider Administration Manual

Beginning in 2019, BlueCross is changing how we publish our online Commercial provider administration manual (PAM).

We're doing this to comply with State of Tennessee Public Chapter No. 88, which requires a health insurance entity to provide notice to a health care provider of any material change made to its previously released provider manual or a reimbursement rule and policy at least sixty (60) days prior to the effective date of change. To accommodate this, we'll begin publishing a special redlined version of the BlueCross Provider Administration Manual **in addition** to the previously released PAM. In this version, providers will be able to easily identify the applicable changes in a red color type.

The redlined version for first quarter 2019 will be published on Feb. 1, 2019, and will allow providers to preview any upcoming billing and reimbursement or policy changes 60 days prior to their actual effective dates. On April 1, 2019 – at the end of the 60-day notice period – both the redlined version and the previously released fourth quarter PAM will be replaced with a single provider administration manual containing all the changes.

This process applies only to our Commercial lines of business and will continue each quarter whenever there are any upcoming changes affecting billing and reimbursement guidelines or policies.



## BlueCare Tennessee

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

### Best Practices for Combining Well-Child Checks with Sick Visits

Sometimes, the only opportunity you have to perform a wellness check is when patients visit your office because of an illness or other need. Combining visits for acute care and other services, such as sports physicals, helps ensure children throughout our state get the preventive care they need.

TennCare Kids' screening guidelines allow you to be reimbursed for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) checkups performed at the same time as other visits. According to the Tennessee Chapter of the American Academy of Pediatrics, you can bill for both a sick and well visit on the same day if the following criteria are met:

- You may report an additional evaluation and management (E/M) service if you find a problem during a wellness check that requires you to provide care beyond the work-up of a normal preventive visit.
- Your documentation for the visit reflects the extra work done during the appointment. There doesn't need to be a separate note, but documentation should clearly reflect a separate problem.

For more information about EPSDT exams, please visit our [TennCareKids Toolkit](#). You can also find free TNAAP EPSDT and coding resources at [TNAAP.org](http://TNAAP.org).

**Note:** This information doesn't apply to CoverKids.



## Contraception Guidelines for Women of Childbearing Age with Opioid Use Disorder

The Division of TennCare is asking for your help in informing women of childbearing age about the risks of chronic opioid use.

Health care professionals should offer all women of childbearing age, including those with opioid use disorder (OUD), noncoercive contraceptive counseling and discuss different forms of birth control, as well as the effectiveness of each method. Whether a woman is on pharmacotherapy for OUD or using opioids for pain control, a conversation about the importance of contraception is critical.

The American College of Obstetricians and Gynecologists recommends offering immediate postpartum long-acting reversible contraception to reduce unintended or short-interval pregnancy. An excellent time to implant these devices is when women are in the hospital after delivery. Please encourage women already in treatment to consider planning their next pregnancy and ensure that they are on safe medications, their treatment status is stable, and they are ready for the stresses of motherhood on top of treatment or recovery.

If you have any questions, please call our Provider Service Line at 1-800-468-9736.

### Reference:

Substance Abuse and Mental Health Services Administration (SAMHSA), Clinical Guidance for Treating Pregnant Women with Opioid Use Disorder, 02 2018

## Updates to the Employment and Community First (ECF) CHOICES Reportable Event Management Process\*

BlueCare Tennessee is changing the criteria for two ECF CHOICES reportable events.

Please see the following changes that will take effect Jan. 1, 2019:

- Tier 1: Vehicle accident while transporting a person resulting in injury or a moving violation with significant risk of harm (e.g., reckless driving or driving under the influence)
- Tier 2: The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of belongings or money valued at \$1,000 or less (i.e., less than the threshold for misappropriation)

We anticipate receipt of a revised ECF CHOICES Reportable Event Reporting Form to reflect these changes. Until the new form is released, please continue to use the [current form](#) and document specifics in the narrative section. We appreciate your help and ask that you please share this information with your team.

## Billing Requirement for Physical, Occupational and Speech Therapy Services

[CMS guidelines](#) define physical, occupational and speech therapy as services ordered, referred or prescribed by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law. To comply with these guidelines, we must reject professional claims for these therapy services that don't list the ordering or referring provider.

For more information about this requirement see the [Electronic Code of Federal Regulations website](#).

# Medicare Advantage

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

## Step Therapy for Certain Medicare Part B Drugs

Beginning Feb. 1, 2019, BlueAdvantage and BlueCare Plus will implement step therapy for certain Part B drugs as part of a patient-centered care coordination program. This will affect members that are new to therapy.

Prior authorization and step therapy will be in line with CMS regulations and required for the following Part B drugs: Aloxi<sup>®</sup>/Sustol<sup>®</sup>, Fusilev<sup>®</sup>, Prolia<sup>®</sup>/Xgeva<sup>®</sup>, Eylea<sup>®</sup>, Treanda<sup>®</sup> and Abraxane<sup>®</sup>. You can view our online medical policies by [clicking here](#).

## BlueAdvantage Outpatient Therapy Authorizations

We've made some outpatient therapy authorization changes, which means we've also changed how you submit these on the web. Use these easy steps to get to the correct web submission forms and route your request appropriately:

- From the [Availity Portal](#), click on the **Authorization Submission/Review** option
- Arrow down to expand the **Authorizations/Advance Determination Submission** section that lists the available forms
- Select the **Outpatient Therapy Form** for outpatient physical therapy, occupational therapy, speech therapy and chiropractic requests
- Choose **Home Health Services Form** for all home health related services (skilled nurse visits, occupational therapy, physical therapy and speech therapy)
- Musculoskeletal (MSK) authorization requests (large joint and spine surgery/pain management) are reviewed by an external vendor so please select the **Inpatient Confinement** or **Outpatient Surgical Procedure Form** (based on place of service) and enter the [MSK code](#) related to the request.

## New BlueCare Plus Prior Authorization Requirements

We're making slight changes to some of our BlueCare Plus prior authorization requirements starting Jan. 1, 2019. The list below shows which medical services require authorization, and the **bold** font indicates what's changed since last year:

- All acute care medical and psychiatric facility, long-term acute care, skilled nursing facility (**three-day inpatient requirement is waived**), and medical and substance abuse rehabilitation facility inpatient admissions
- Select musculoskeletal surgical procedures (list of procedures will be posted on website)
- Part B/specialty pharmacy medications
- Durable medical equipment for purchase if the purchase price is greater than \$500
- Durable medical equipment rentals
- Orthotics and prosthetics if the purchase price is greater than \$200
- Outpatient speech, occupational and physical therapy high-tech imaging
- Non-emergency out-of-network services
- Home health to include all therapies, nursing visits and psychiatric visits
- Non-preferred brands of diabetic testing supplies
- Non-emergency ambulance transportation
- **Home ventilator devices**
- **Wearable defibrillator devices**
- Psychiatric residential facilities
- Detoxification services
- Partial Psychiatric Hospitalization Program **excludes substance abuse**
- Psychiatric day treatment
- Applied behavioral analysis
- Electroconvulsive therapy
- Psychological testing



## BlueCare Plus Reimbursements for Patient Readmissions

In conjunction with the CMS Hospital Readmissions Reduction Program, BlueCare Plus will reimburse for acute care hospital readmissions that occur within 31 days from the index admission discharge as follows:

- Facilities aren't eligible for two DRG inpatient payments if a same or similar diagnosis readmission occurs within three to 31 days from a complication of the original hospital stay or admission that results from a modifiable cause related to the index admission discharge diagnosis. This applies to readmission to the same or similar facility or any other facility operating under the same contract.
- The facility will be reimbursed for a single inpatient DRG (the higher weighted of the two admissions) only. All other days will be reimbursed under DRG outlier methodology and may be subject to concurrent inpatient medical review for medical necessity.
- A same or similar diagnosis readmission that occurs within 48 hours of an acute care hospital discharge from the same or similar facility, or facility operating under the same contract, will not be reimbursed regardless of the length of stay. CMS considers a short-term readmission for the same or similar diagnosis to generally be due to a process failure in discharge planning or due to the member not being clinically stable at the time of the original discharge.
- BlueCare Plus readmission guidelines are less stringent than the Readmission Reduction Program guidelines for original Medicare in that they don't penalize a facility for all diagnoses that could lead to a readmission or adjust all Medicare payments. We apply the policy for a same or similar diagnosis from the index admission discharge diagnosis, and only for the member who is readmitted.
- The program is designed to encourage you to address transition of care options. CMS considers 31-day readmissions to be an indicator of quality of care.

Please note:

- Members can't be held liable for denied charges associated with a readmission within 31 days of a previous admission as indicated above.
- Standard facility appeal remedies are applicable.



### Proper Coding for Influenza Vaccine

Please bill your patient's flu shot claims using the appropriate influenza vaccine CPT® code and ICD-10 Z23, along with administration code G0008.

### Provider Assessment Form Reimbursement for 2019

In 2019, you'll again be eligible to receive payments for completing and submitting a Provider Assessment Form (PAF) for your attributed BlueAdvantage patients.

Please use CPT® code 96160 to file a PAF.

BlueAdvantage will continue to reimburse the service with a maximum allowable charge of:

- \$225 for dates of service between Jan. 1, and June 30, 2019
- \$175 for dates of service between July 1, and Dec. 31, 2019

To receive reimbursement, please submit the form through Availity or fax it to 1-877-922-2963. You should also include the form in your patient's chart as part of their permanent record. The 2019 form will be available online Dec. 1, 2018.

You don't need to wait 365 days between PAF submissions because the benefit is each calendar year. For additional information about the PAF, please visit [bcbst.com/providers/quality-initiatives.page](http://bcbst.com/providers/quality-initiatives.page).

**Reminder:** To be included in the 2018 measurement year, BlueCross must receive 2018 PAFs by Jan. 31, 2019.

### New Vendor Equian to Conduct Supplementary Post-Payment Claims Review

Starting in 2019, BlueAdvantage will work with Equian, a Medicare Advantage business associate, to perform post-payment claims reviews to verify payment accuracy. Equian will conduct both data mining and medical record reviews in full compliance with HIPAA requirements.

If you have any questions, please contact [Tony Carchietta](#) at (423) 535-3590.

### Genetic Testing Covered Once Per Lifetime

Genetic tests, which require prior authorization, are only covered once during a member's lifetime, unless the U.S. Food and Drug Administration specifically approves more tests.

For out-of-network testing, we recommend getting a predetermination first so the member isn't charged for tests that may not meet Medicare coverage guidelines. Services provided by an out-of-network genetic testing provider will be reviewed before payment if a predetermination was not obtained to ensure medical necessity against Medicare coverage criteria.

# Quality Care Partnerships

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

## Measures Applicable to Quality Amendments

Our BlueAdvantage plans will be sending quality amendments for 2019. Below is the list of measures included in the 2019 program. Please speak with your Quality Incentive Consultant if you have any questions.

### Measures Applicable to Quality Amendments

Measure Name	Measure Type	Weight	2019 Star Ratings Projected Cut Point			
			2-star	3-star	4-star	5-star
Breast Cancer Screening	Process (Non-Continuous)	1	50%	71%	79%	85%
Colorectal Cancer Screening	Process (Non-Continuous)	1	59%	65%	74%	81%
Osteoporosis Management in Women Who Had a Fracture	Process (Non-Continuous)	1	35%	48%	62%	86%
Diabetes Care - Eye Exam	Process (Non-Continuous)	1	58%	66%	75%	82%
Diabetes Care - Kidney Disease Monitoring	Process (Non-Continuous)	1	2%	89%	97%	99%
Diabetes Care - Blood Sugar Controlled	Outcome (Continuous)	3	41%	70%	80%	89%
Statin Use in Persons with Cardiovascular Disease	Process (Non-Continuous)	1	72%	78%	83%	87%
Rheumatoid Arthritis Management	Process (Non-Continuous)	1	73%	80%	88%	92%
Medication Reconciliation Post Discharge	Process (Non-Continuous)	1	40%	57%	69%	82%
Plan All-Cause Readmission	Outcome (Continuous)	3	11%	9%	8%	4%
Medication Adherence - Diabetes	Outcome (Continuous)	3	74%	80%	83%	87%
Medication Adherence - Hypertension	Outcome (Continuous)	3	84%	88%	90%	91%
Medication Adherence - Statin	Outcome (Continuous)	3	75%	79%	86%	90%
Statin Use in persons with diabetes	Outcome (Continuous)	3	74%	78%	82%	85%

**Note:** Measures and cut points for the Medicare Advantage Star Ratings Program are determined by CMS and based on prior year performance of all MA plans. To adjust for industry improvement in the upcoming year, we can adjust the cut points based on statistical analysis of industry trends from prior years' performance.

**Our offices will be closed Dec. 24, and 25, 2018,  
and Jan. 1, 2019, in observance of the holidays.**

BlueCross BlueShield of Tennessee complies with the applicable federal and state laws, rules and regulations and does not to 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.

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. 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.

\*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](#).

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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.

**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

**TennCareSelect** 1-800-276-1978

**CoverKids** 1-800-924-7141

**CHOICES** 1-888-747-8955

**ECF CHOICES** 1-888-747-8955

**BlueCare Plus<sup>SM</sup>** 1-800-299-1407

**BlueChoice<sup>SM</sup>** 1-866-781-3489

**SelectCommunity** 1-800-292-8196

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

Email: [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)



PROVIEW™

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