

BlueAlertSM

BlueCross BlueShield of Tennessee, Inc.

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

Musculoskeletal and Pain Management Prior Authorization Changes

We want to remind you about an important change to our Musculoskeletal (MSK) and pain management prior authorization process because it could impact some of your patients. You'll need to contact us for all MSK and pain management authorizations for BlueCareSM, TennCare^{Select}, BlueCare Plus (HMO SNP)SM and BlueAdvantage (PPO)SM members. The list of procedures and services requiring prior authorization won't change.

Please note we're not changing the prior authorization process for our fully insured and select self-funded Commercial members. TurningPoint Healthcare Solutions, LLC, will continue administering these authorizations.

For MSK or pain management prior authorizations, please call or fax:

BlueCare Tennessee

Phone: 1-888-423-0131

Fax: 1-800-292-5311

TennCare^{Select}

Phone: 1-800-711-4104

Fax: 1-800-292-5311

BlueCare Plus

Phone: 1-866-789-6314

Fax: 1-866-325-6698

BlueAdvantage

Phone: 1-800-924-7141

Fax: 1-888-535-5243

Commercial

Phone: 1-866-747-0586

Fax: 1-866-747-0587

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ALL Blue 2019

Register for an All Blue Workshop 2019 in a City Near You

Registration is now open for our annual All Blue Workshops. Space is limited, so sign up today.

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

60-Day Preview Version of Provider Administration Manual Now Available

We're now publishing a preview of the BlueCross BlueShield of Tennessee Provider Administration Manual (PAM) that shows changes that will become effective 60 days later. The Preview PAM doesn't replace the PAM, but is a supplement that highlights added, replaced or removed language, so your office has time to prepare for the upcoming changes. The new Preview PAM includes changes that will be effective April 1, 2019.

Note: This information doesn't pertain to the BlueCare Tennessee Provider Administration Manual.

Get the Answers You Need Through Availity®

Through Availity, you can get the answers you need 24 hours a day, seven days a week. Not only can you transact with us online, you have access to other payers, too – all through one convenient portal.

Log in today to:

- Request claim status
- View remittance advice
- Check benefits and eligibility status
- Access other BlueCross applications and updates on the BlueCross-specific Payer Space

To reduce hold times on the phone, please log in to [Availity](#) for common transactions – especially benefits and eligibility inquiries. Our phone team is no longer able to answer these questions, unless you can't find what you need online. In this case, the system will send you a Fast Path code to get benefits and eligibility help by phone. (For now, Dental providers can still call for this information.)

Need Help Getting Started?

If you need help getting your office started with Availity, contact your [eBusiness Regional Marketing Consultant](#) for training and education or visit [Availity.com/bcbst](#).

For questions about the Availity Web Portal, please call Availity Client Services at 1-800-AVAILITY (1-800-282-4548), Monday through Friday from 8 a.m. to 7 p.m. ET, excluding holidays.

Eligibility and Benefits Enhancements in Availity

As When checking eligibility and benefits through Availity, you'll notice several new enhancements:

- An acupuncture benefit option has been added to Benefit/Service Type.
- More options are now available in Health Benefit Plan Coverage benefit type:
 - Physical Therapy
 - Speech Therapy
 - Occupational Therapy
 - Radiation Therapy
 - Durable Medical Equipment
 - Durable Medical Equipment Purchase
 - Durable Medical Equipment Rental
- Individual Market Members' PCP information is no longer populated.
- Patient relationship has been added to Patient Information, e.g., spouse of subscriber.

To check eligibility and benefit information, you can simply log in to Availity, click Patient Registration and then Eligibility and Benefits Inquiry.

If you have questions, please contact your [eBusiness Regional Marketing Consultant](#).

Cite Guideline Transparency Tool Now Available

MCG has provided a product called Cite Guideline Transparency (CGT) so you can see MCG and BlueCross BlueShield of Tennessee medical content before requesting an authorization. You can access the tool in Availity or on our Utilization Management web page under the Cite Guideline Transparency link, where you'll also find the CGT quick reference guide.

If you have questions, please contact your [eBusiness Regional Marketing Consultant](#).

New Prior Authorization Requirements for Oncology/Radiation Therapy

Beginning April 1, 2019, prior authorization for certain oncology/radiation therapy procedures will be required for some Commercial members. Previous articles in BlueAlert indicated a March 1 effective date, but it's been extended to April. You can check member benefits through Availity Self-Service. For more details on how to do this, please see the Eligibility and Benefits Enhancements in Availity article in this issue.

Changes to Genetic Testing Program Prior Authorization for Commercial Plans

Beginning April 1, 2019, CPT® code 0081U for genetic testing will require authorization by eviCore.

Before requesting prior authorization, please verify member benefits and eligibility by logging in to [Availity](#) and clicking Patient Registration then Eligibility and Benefits Inquiry.

Prior authorization requests can be submitted through [Availity](#). You can also fax them to eviCore at 1-888-693-3210 or by calling 1-888-693-3211.

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. The itemized bill should be submitted through the faxed paperwork (PWK) attachment process. If we don't receive the required documents, your claims may be denied or returned.

Non-Emergency Air Transport Requires Prior Authorization for FEP Members

If you want to request air ambulance transport for a BlueCross member covered by a Standard, Basic or BlueFocus Federal Employee Program plan, please know you may need to get authorization from BlueCross before the flight. Air transport for emergencies (e.g., from the scene of an accident when ground transport isn't appropriate or would pose a threat) doesn't require approval. Air transport for non-emergencies do.

To arrange non-emergent air ambulance transport for a patient with BlueCross FEP benefits, please call 1-800-572-1003 from 8 a.m. to 6 p.m. ET. This prior authorization requirement may affect your FEP BlueFocus and Basic Option members if an out-of-network air ambulance is used for non-emergency transportation.



2019 HEDIS® Medical Record Requests to Begin

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

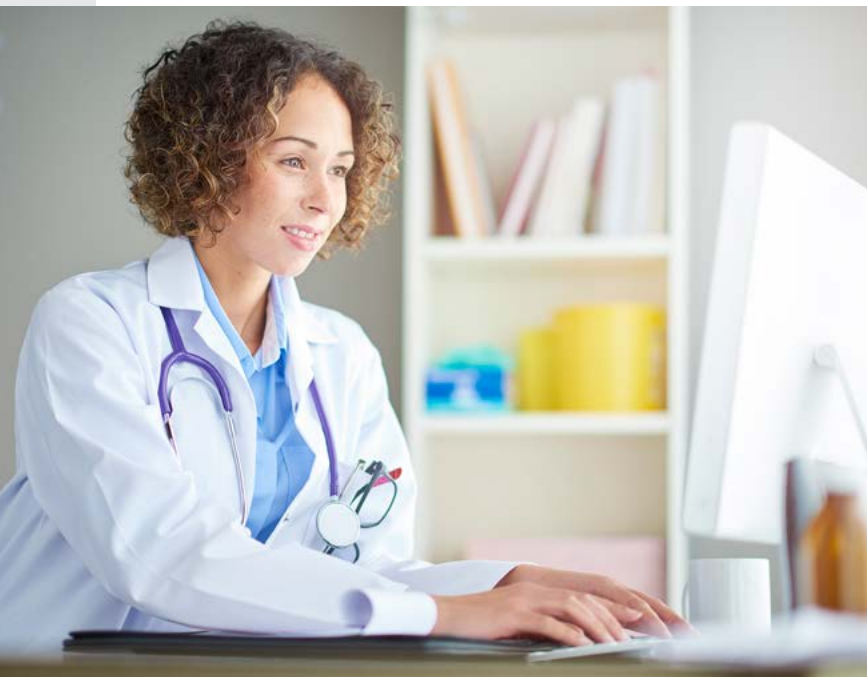
Soon, you'll receive a request for medical records related to prevention and screenings, diabetes care, cardiovascular conditions, prenatal/postpartum care, medication management and well-child visits.

For help coordinating your record submission using any of these methods call us at (423) 535-3187.

- Remote access into your EMR
- Secure email
- Fax
- On-site collection
- Our web-based portal

We appreciate your help supporting this requirement.

HEDIS® is a registered trademark of the NCQA.



Tips for Coding Professionals

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

Correct Coding – Usage Changes for Right and Left Modifiers Used Bilaterally

CMS has published new guidelines for modifiers billed by DME Providers for dates of service on or after March 1, 2019. New coding guidelines require each item to be billed on separate claim lines using the RT and LT modifiers with one unit of service (UOS) on each claim line. Claim lines for HCPCS codes requiring use of the RT and LT modifiers, billed without the modifiers or with the modifiers on a single claim line, will reject as incorrect coding.

If you need to bill two of the same items or accessories on the same date of service and used bilaterally, current requirements state you should use RT and LT modifiers on the same claim line and indicate two units of service. For more information, please see

[Tennessee’s Durable Medical Equipment \(DME Medicare Administrative Contractor \(MAC\) For Jurisdiction C.](#)

Correct Use of Modifiers for Procedure-to-Procedure Edits

In October, we published a coding guideline to help providers avoid claim payment delays from using incorrect modifiers for procedure-to-procedure edits. We ask that you review the information to help correct these claim submission errors.

Each National Correct Coding Initiative procedure-to-procedure (PTP) edit has a modifier indicator of 0, 1 or 9.

- Modifier indicator 0: NCCI-associated modifiers can't be used to bypass the edit.
- Modifier indicator 1: NCCI-associated modifiers may be used to bypass an edit in appropriate circumstances.
- Modifier indicator 9: the edit was deleted and the modifier indicator is not relevant.

When an edit may be bypassed by a modifier, and a modifier is clinically supported, the modifier should only be appended to the column two or “bundling” code. While the modifier may be accepted on the comprehensive codes in some instances, it shouldn't be appended to both codes in the code edit pair. This can delay the processing and payment of claims.

New CPT® Codes for Psychological and Neuropsychological Testing

As of Jan. 1, 2019, we've adopted the new CPT® codes for psychological and neuropsychological testing required by the American Medical Association (AMA). Please use them for all claims for dates of service after Jan. 1, even if the tests were authorized prior to that date. You can amend or request a retroactive approval to your prior authorization request to include newly covered services (e.g. feedback sessions) if you submitted your request before Jan. 1.

Please note: If you don't use these new codes after Jan. 1, your claims will be denied.

However, prior authorization requirements for these tests remain the same.

To order copies of the CPT® manual from the AMA, visit commerce.ama-assn.org/store or call 1-800-621-8335. If you have questions, please contact your regional Provider Network Manager.

BlueCare Tennessee

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



Brush Up on the Required Parts of a TennCare Kids Checkup

TennCare Kids Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams have seven key components:

- Comprehensive health (physical and mental) and developmental history
 - Initial and interval history
 - Developmental/behavioral assessment
- Comprehensive unclothed physical exam
- Vision screening
- Hearing screening
- Laboratory tests
- Immunizations
- Health education/anticipatory guidance

When your BlueCare Tennessee patients receive their well-child checkups, please document all seven required parts of the exam, as well as assessments of your patients' nutrition and physical activity.

If the patients are uncooperative or the exams were deferred or refused, please be sure to include this information in the patients' medical records.

For more information about the required components of TennCare Kids EPSDT exams and medical record documentation requirements, please visit our [TennCare Kids provider page](#).

Note: This information doesn't apply to CoverKids.

Changes to the TennCare Preferred Drug List

Recent releases of the Division of TennCare Preferred Drug List (PDL) include changes that may affect some of the medications your patients take. Please see below for notable updates.

Effective Nov. 1, 2018

Coreg CR is no longer on the list of branded agents classified as generics, and requests for this medication will be denied. You can transition patients previously taking this drug to carvedilol CR, which is covered for patients with existing prior authorizations.

Effective Jan. 1, 2019

The PDL status changed for certain drugs in the anti-infectives, cardiovascular, central nervous system, endocrine and metabolic, gastrointestinal, oncology agents, and ophthalmics covered drug classes.

To view the full provider notices outlining these PDL changes, please see the Provider Notice for Brand as Generic Removals – Effective Nov. 1, 2018 and Provider Notice for PDL Changes Effective Jan. 1, 2019, documents under Announcements in the [News and Manuals Provider section of bluecare.bcbst.com](#).

Note: The TennCare PDL doesn't apply to CoverKids members.

Reimbursement Update for CPT® Code 90460*

The reimbursement rate for CPT® code 90460 recently increased for providers delivering vaccines through the Vaccines for Children program. Effective Mar. 1, 2019, providers delivering vaccines to children covered by BlueCare and TennCare *Select* will receive reimbursement according to the standard BlueCare and TennCare *Select* fee schedule.

CPT® code 90460 is the administration code for immunizations given to children and teens age 18 and under via any administration route, with counseling by a physician or other qualified health professional, for the first or only vaccine/toxoid component. To learn more about this and other pediatric immunization administration codes, please visit [Frequently Asked Questions for the Pediatric Immunization Administration Codes](#) on the American Academy of Pediatrics website.

Note: This reimbursement update doesn't apply to CoverKids.

New Applied Behavior Analysis Referral Form Available Online

We want to make Applied Behavior Analysis (ABA) referrals as easy as possible. So we've updated our ABA referral form and posted it [online](#). The new form includes more fields for patient information, and features larger areas for details about diagnoses.

To use the new form, simply download it, fill it out digitally or by hand, and then send it to us by email or fax. This form will allow us to process your referrals more quickly and help you provide the best care possible for your ABA patients.

New Procedure for Reporting Home Health Missed Visits

The Division of TennCare recently made several changes to the process for reporting missed home health visits. Effective Jan. 1, 2019:

- Home health agencies must have a back-up plan to handle missed visits for each member. This back-up plan should trigger as soon as an agency learns a missed visit is in progress or will take place.
- Agencies must report missed visits within three calendar days by submitting a completed [Home Health Missed Visit Form](#). This form includes directions for submission, as well as necessary fax numbers.
- **If there is no back-up plan in the home or if a member refuses two or more home health staff members, please call us immediately.** Please see the Home Health Missed Visit Form for our contact phone numbers.

Medicare Advantage

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



Expanded Dental Benefits for BlueAdvantage (PPO)SM Dental Members

We've expanded our dental benefits so you can provide more preventive and comprehensive services for our BlueAdvantage members in 2019.

Our 2019 plans offer an allowance for routine and comprehensive dental services combined. Here's a list of services we cover:

- Cleanings (up to two per year)
- Exams (up to two per year)
- Up to one dental bitewing (limited to four films in a calendar year; all films must be taken on the same date of service).
- Fillings
- Extractions
- Endodontics
- Prosthodontics
- Oral/maxillofacial surgery
- Dentures (up to one set every three years)

Please note this may not be an all-inclusive list.

Covered dental services are allowed at 100% of the maximum allowable of the Commercial Fee Schedule for covered services up to the member's annual maximum.

For more information, please review the member's Dental Benefit information on Availity. If you have any additional questions, please call Provider Service at 1-800-924-7141.

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 who are new to therapy.

Prior authorization and step therapy will be in line with CMS regulations and will also be required for the following Part B drugs: Aloxi/Sustol, Fusilev, Prolia/Xgeva and Eylea. Treanda and Abraxane were previously listed in December and January BlueAlert articles but no longer require step therapy. You can view our online medical policies by [clicking here](#).

BlueCare Plus Model of Care Training

BlueCare Plus providers are contractually required to complete our Model of Care Training after initial contracting, then every year afterwards. This training is designed to promote quality of care and cost effectiveness through coordinated care for our dual-eligible Medicaid and Medicare members with complex, chronic or catastrophic health care needs. You can access the online self-study training and attestation by [clicking here](#).

BlueAdvantage and BlueCare Plus Prior Authorization Criteria for Long-Acting Opioids

BlueCross continues to require prior authorization (PA) for long-acting opioids in 2019. In order for us to process your patient's prior authorization for a long-acting opioid, please provide:

- Documentation of the diagnosis and assessment for the requested drug including:
 - Nature and intensity of pain
 - Past and current pain treatments
 - Underlying or concomitant disorders and conditions
 - Effect of pain on physical and psychological function
 - Physical exam
 - Review of medical history
 - Lab results
- Attestations for:
 - Pain management agreement (signed by the patient and provider in the past six months)
 - Completed aberrant behavior risk assessment tool – such as a Screener and Opioid Assessment for Patients with Pain (SOAPP) for a new opioid user, or a Current Opioid Misuse Measure or Opioid Risk Tool (ORT) for a current opioid user.
 - Review of the state's controlled substance database within the last 90 days
 - Treatment plan that includes goals and monitoring (signed by the patient and the provider)
 - Previous treatment with short-acting opioids at the lowest morphine milligram equivalent dose possible

While these are some of the most important elements, we may require others to complete the prior authorization. Please [click here](#) to view the entire policy on the Use of Opioids in Control of Chronic Pain.

To Request Prior Authorization for Your Patients

- **BlueAdvantage:** Call 1-800-831-2583 or fax your request to (423) 591-9514.
- **BlueCare Plus:** Call 1-800-299-1407 or fax your request to (423) 591-9514.

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.

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 completed form through Availity or fax it to 1-877-922-2963. You also include the form in your patient's chart as part of their permanent record. The 2019 form will be available online soon.

You don't need to wait 365 days between PAF submissions because the benefit is each calendar year. Please see our website for [more information about the PAF](#).

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

Post-Service Audit Focuses on High-Level Emergency Department E&M Coding

BlueAdvantage and BlueCare Plus now audit claims with Level 5 emergency department E&M codes to verify the discharge diagnosis justifies high-complexity E&M coding. Claims billed with inappropriate E&M codes will be denied, and you'll need to file with a lower acuity E&M or request an appeal. The audit addresses what CMS notes as a sharp increase in Level 5 emergency department coding. This denial is not stating that the services were not emergent in nature, but rather that the level of coding is unlikely representative of the intensity of services provided in the emergency setting. It isn't to evaluate whether an emergency existed under the Prudent Layperson Standard or the requirement of a Medical Screening Exam under the Emergency Medical Treatment and Active Labor Act.

Quality Care Partnerships

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



Statin Use for BlueAdvantage Patients with Cardiovascular Disease

The amendment for the 2019 Quality Care Partnerships includes a new performance measure: Statin Therapy for Patients with Cardiovascular Disease. The metric measures the percentage of male members age 21-75 and female members age 40-75, who were identified as having **atherosclerotic cardiovascular disease** and received at least **one** prescription for a **high- or moderate-intensity statin**.

One of the following drugs must be prescribed and dispensed by a pharmacy:

- Atorvastatin
- Fluvastatin
- Lovastatin
- Pravastatin
- Rosuvastatin
- Simvastatin

Note: Heart disease is identified through medical claims for the following diagnosis:

- Ischemic vascular disease
- Myocardial infarction, coronary artery bypass grafting, or a revascularization event such as percutaneous coronary intervention

THCII Episodes of Care Program

New Quarterly Reports for both Medicaid and Commercial will be available sometime in February to Quarterbacks participating in the Episodes of Care Program. If you are a Quarterback having trouble accessing your Quarterly Report, please contact eBusiness Support (423) 535-5717 and press option 2 or by email at eBusiness_service@bcbst.com for assistance.

Measures Applicable to Quality Amendments

Our BlueAdvantage plans have set 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.

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](#).

CPT® is a registered trademark of the American Medical Association

BlueCross BlueShield of Tennessee, Inc. and BlueCare Tennessee are Independent Licensees of the BlueCross BlueShield Association

† 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 p.m. (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 PlusSM	1-800-299-1407
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
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.