of Tennessee

JANUARY 2019

BlueAlert℠

BlueCross BlueShield of Tennessee, Inc.

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

Important Changes to Musculoskeletal and Pain Management Prior Authorizations

We want you to know about an important change to our Musculoskeletal (MSK) and pain management prior authorization process because it could impact some of your patients. You now need to contact us for all MSK and pain management authorizations for BlueCare Tennessee, TennCare*Select*, BlueCare Plus (HMO SNP)℠ and BlueAdvantage (PPO)℠ 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

INSIDE THIS ISSUE

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 single sign-on.

Log in today to:

- Request claim status
- View remittance advices
- 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 everyday 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 your office needs help getting 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, 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

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 by default within the **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
- Patient relationship has been added to Patient Information, e.g., spouse of subscriber

If you're not using Availity 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. Thank you for using all of Availity's self-service features.

Click to Chat Feature Now Available Through Availity

As we continue to make enhancements to our customer service area, we've started a "Click to Chat" feature that offers you a new way to communicate with us in addition to email and phone. Click to Chat is available in the Payer Space on Availity and is reserved for questions you would normally ask our eBusiness area. For now, Click to Chat isn't available for claim status or benefit and eligibility questions, but we plan to include it in the future.

New BlueCross Opioid Prescription Policy Now in Effect

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 to help our members and eventually all Tennesseans get the appropriate amount of opioids for their medical conditions.

Effective Jan. 1, 2019, the following changes are in effect for our Commercial (Blue Network P℠, Blue Network S℠ and Blue Network M℠) and CoverKidsSM 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
- 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
- Sickle Cell Disease
- Palliative Care
- End of Life Care

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

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

Understanding our Member's Rights and Responsibilities

We periodically remind members of their rights and responsibilities. These reminders make it easier for our members to access quality medical care and additional services. And these reminders help us comply with regulatory and accrediting requirements.

For your convenience, we publish our current member rights and responsibilities online in our provider manuals. These are available in the Quick Links section of our website.

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. Please submit your itemized bills through the faxed paperwork (PWK) attachment process. If we don't receive the required documents, your claims may be denied or returned.

New Coverage Option for Federal Employees

Federal Employee Plan (FEP) members now have a third coverage option. In addition to Standard Option and Basic Option coverage, FEP Blue Focus℠ gives federal employees, especially individuals just entering the workforce, an opportunity to choose a lower-cost 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.

Autoimmune Infusion Benefit Procedure Changes for Federal Employee Program Members

Starting Jan. 1, 2019, 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.

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

As mentioned in our August through December BlueAlert newsletters, we're resuming 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.

New Prior Authorization Requirements for Oncology/Radiation Therapy

Beginning March 1, 2019, prior authorization for certain oncology/radiation therapy procedures will be required for some Commercial members. You can check member benefits through Availity Self-Service. For more details on how to do this, please see the Check Eligibility and Benefits Through Availity Self-Service Feature article in this issue.

Tips for Coding Professionals

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

New CPT® Codes for Psychological and Neuropsychological Testing

Beginning Jan. 1, 2019, we're adopting 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 as of Jan. 1, even if the tests were authorized prior to that date. You're welcome to 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.

HCPCS G Codes No Longer Required for Physical and Occupational Therapy

Effective Jan. 1, 2019, in alignment with CMS, our BlueAdvantage and BlueCare Plus Medicare Advantage plans no longer require the reporting of functional status (G Codes) related to physical therapy and occupational therapy services. Claims processing and reimbursement will not be impacted if you still choose to file the G Codes.

BlueCare Tennessee

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

Changes to TennCare Preferred Drug List

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

Changes Effective Nov. 1, 2018

Narcan Nasal Spray no longer requires prior authorization for certain patients.

Changes Effective Dec. 1, 2018

Focalin IR is no longer on the list of branded agents classified as generics, and requests for this medication will deny. You can transition patients previously taking this drug to Dexmethylphenidate immediate release, which now has preferred status and is covered for patients with existing prior authorizations.

To view the full provider notices outlining these PDL changes see the Provider Notice for Brand as Generic Removals and Provider Notice for Narcan Nasal Spray documents under Announcements in the News and Manuals Provider section of bluecare.bcbst.com.

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

Explore the Difference between EPSDT and HEDIS®-Compliant Well-Child Exams

There are key differences between the reporting criteria for TennCare Kids' Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams and the well-child-visit performance measures outlined by the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS). Here's what you need to know.

EPSDT Visits

Children and adolescents enrolled in BlueCare℠ or TennCare*Select* are eligible for TennCare Kids exams from birth until their 21st birthday. The schedule for EPSDT exams follows the American Academy of Pediatrics Periodicity Schedule.

The fiscal year for EPSDT visits begins Oct. 1 and ends Sept. 30 of the following year. Patients are eligible as long as they've had BlueCare Tennessee coverage for 90 continuous days at some point during the fiscal year.

HEDIS Quality Measures

Three performance measures apply to well-child checkups. These measures evaluate whether or not children and adolescents receive the appropriate number of checkups during three key stages: during their first 15 months of life, between ages 3 and 6, and between ages 12 and 21.

The measurement year for HEDIS begins Jan. 1 and ends Dec. 31. To count among a primary care provider's patient population, children must be enrolled in their health plan during the entire calendar year. However, the measures allow one gap in coverage of up to 45 days.

The standalone and diagnosis codes for EPSDT and HEDIS well-child visits are the same; however, you must also include a corresponding CPT® code when billing an EPSDT visit with a listed diagnosis code. For more information about EPSDT exams and coding, please visit our TennCare Kids Toolkit.

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

BlueCare Tennessee 'Pay-and-Chase' Guidelines Change

Patients enrolled in BlueCare℠ or TennCareSelect may also have other insurance. In these cases, providers should bill patients' primary insurance before billing BlueCare Tennessee. TennCare is nearly always considered secondary to other third-party payers.

Sometimes, providers don't realize that patients are enrolled with another insurance carrier before they bill us. In these cases, we may recover payment from providers if certain criteria are met. However, in accordance with federal laws and our contractual agreement with the Division of TennCare, we're required to pay some claims using the "pay-and-chase" approach. This means we'll attempt to recover payment from patients' other insurance, not the provider.

Please note the services for which we're required to use the "pay-and-chase" method have recently changed for pregnant women over age 21. We no longer have to include claims for services delivered to pregnant women over age 21 in the pay-and-chase method.

The Division of TennCare still requires using the "pay-and-chase" approach to pay claims |for the following:

- Preventive pediatric services (including EPSDT exams)
- Services to children on whose behalf child support enforcement is being carried out by the state Title IV-D agency

As a reminder, you may opt to file claims to BlueCare Tennessee as the primary carrier for "pay-and-chase" services, but submitting claims to patients' other carrier first may result in a higher reimbursement rate.

If you have questions, please see The Role of TennCare MCOs in Third Party Liability TennCare Policy Manual. Your provider agreement also outlines information about third-party liability.

Note: This doesn't apply to CoverKids.

Medicare Advantage

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

CMS Opioid Prescription Changes for 2019 Affect Medicare Advantage Plans

The Centers for Medicare and Medicaid Services (CMS) has changed their opioid prescribing guidelines effective Jan. 1, 2019, and they apply to all Medicare Advantage plans. The changes include:

- Prescriptions are limited to a total of 90 morphine milligram equivalent (MME◆) per day.
- Prescriptions for acute pain are limited to seven days for members who don't regularly take an opioid prescription.

More details about the CMS changes are available at their website.

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

Clinical Trial Information

Please report a clinical trial number on your claims for items or services provided in clinical trials, studies, registries or under coverage with evidence development (CED). This is the number assigned by the National Library of Medicine (NLM) ClinicalTrials.gov website when a new study appears in the NLM Clinical Trials database.

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, Eylea, Treanda and Abraxane. You can view our online medical policies by clicking here.

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 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 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.

Reminder: Administrative Approvals for Home Health, Physical Therapy, Occupational Therapy, Chiropractic and Speech Therapy

BlueAdvantage offers administrative approvals on the initial request for the following services with notification and diagnosis only:

- Home Health Skilled Nursing: Up to 13 visits over a 30-day timeframe (12 visits plus evaluation)•
- PT and OT (home health or outpatient): up to 13 visits over a 30-day timeframe (12 visits plus evaluation)•
- Chiropractic request for spine only (cannot be for maintenance therapy per Medicare guidelines): up to eight visits over a 30-day timeframe (no evaluation related to these services)
- Speech Therapy: Up to seven visits over a 30-day timeframe (six visits plus evaluation) *

•The initial evaluation visits do not require prior authorization. The authorizations will only include the total number of visits and timeframe approved, excluding the evaluation, which does not require a separate authorization.

Clinical information for these administrative approvals is not required other than a diagnosis. Additional requests beyond the initial visit approval and/or timeframe above are considered an extension, and clinical documentation for a medical necessity review is required. If the patient needs more than the number of allowed visits within or beyond the 30-day timeframe of your initial request, please send us supporting documents for a medical necessity review.

If you need to request more than the number of allowed visits noted within or beyond a 30-day timeframe on your initial request, please submit all supporting documentation for medical necessity review.

You may request prior authorization by logging in to the BlueCross payer space in the Availity Provider Portal or by calling 1-800-924-7141.

- In 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. Please select the Inpatient Confinement or Outpatient Surgical Procedure Form (based on place of service) and enter the MSK code related to the request.

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

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.

Pending Gap Closure Attestation

If you use the BlueCross Quality Care Rewards portal, please review your queue for any pending attestations to close outstanding gaps in care. You must submit pending attestations from the queue **before Jan. 31, 2019**, to be counted for the 2018 measurement year.

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 TennCare*Select*. 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.

CAQH Solutions | PROVIEW™

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

† Provider Service Lines

Featuring "Touchtone" or "Voice Activated" Responses

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
TennCare*Select*	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
BlueChoiceSM	1-866-781-3489
***Select*Community**	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)	