of Tennessee

JANUARY 2023

BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

A monthly newsletter for the BlueCross BlueShield of Tennessee, Inc. (BlueCross) provider community, featuring important updates and reminders about our company's policies.

All Lines of Business

(Unless Stated Otherwise)

COVID-19 Updates

Throughout the COVID-19 pandemic, we've made changes to help our members and providers stay safe. Please continue to visit the Provider FAQs at **bcbstupdates.com** for up-to-date guidelines on how we've updated our policies to help you care for our members.

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News About Digital Member ID Cards

Starting Jan. 1, 2023, you may notice more members using a digital Member ID. While we've offered the option for some time, we're now encouraging increased use of digital IDs for many of our commercial members.

You'll be able to find the same information as that listed on the plastic Member ID card. Simply ask your patient to share their digital ID through our BCBSTN℠ app or Apple Wallet. You can also find useful Member ID information behind Availity®.

Understanding Our Members' Rights and Responsibilities

We periodically remind our members of their rights and responsibilities. These reminders make it easier for them to access quality medical care and additional services. It also helps us comply with regulatory and accreditation requirements. For your convenience, we publish our current member rights and responsibilities in our **Provider Administration Manuals**.

New Member Service Resource Team for Tennessee Providers

To help support Tennessee-based providers and members, we've assigned a specially trained member service team to answer provider questions about medical benefits, coverage and eligibility for members who are pregnant as the result of rape or incest, or who are facing a non-viable pregnancy. These representatives are also able to provide information about behavioral health benefits, coverage and eligibility.

To reach the team, please call **1-866-268-3502**, from 8 a.m. to 6 p.m. ET.

Register for Electronic Funds Transfer to Complete Your BlueCross Enrollment

As of September 2022, all new enrolling providers are required to register for Electronic Funds Transfer (EFT) with Change Healthcare before they can be enrolled with us. To sign up, just visit Change Healthcare's Payer Enrollment Services portal at **payerenrollservices.com**, which is also accessible through Availity® and **provider.bcbst.com**. It's easy and Change Healthcare can process your EFT request within 10 business days. You can sign up for Electronic Remittance Advice (ERA) through their portal as well.

If you're already an in-network provider and you're receiving payments and remittance advice as intended today, there's nothing you need to do. If you have questions, please call **1-800-924-7141** and follow the prompts to eBusiness Technical Support. You can also reach out to your Provider Network Manager.

BlueCross Offering Contracts in North Georgia

As of Nov. 1, 2022, we began offering certain employer group health plans in Catoosa, Dade and Walker counties in Georgia. We're able to do this because we're licensed by the Blue Cross Blue Shield Association for these specific counties outside Tennessee. Providers interested in becoming contracted in our Commercial and Medicare Advantage networks should visit our website and follow the steps for enrollment and credentialing or contact our Provider Service line at **1-800-924-7141** and then follow the prompts to select Contracts and Credentialing.

Note: The information in the article above doesn't apply to the Federal Employee Program (FEP). Additionally, all providers located in Catoosa, Dade and Walker Counties should know that with this change, our BlueCross BlueShield of Tennessee member claims for services rendered in these three counties are no longer processed through BlueCard®. Instead, pricing and benefits are handled by BlueCross BlueShield of Tennessee directly. Now, providers located in one of these counties that treat our members must be contracted with us for our members to receive in-network benefits. For questions about these claims, please contact your Provider Network Manager or call our Provider Service line at **1-800-924-7141**.

Using Self-Service Options for Claim Status Updates

Looking for the fastest way to get a claim status update? We offer a variety of self-service options so you can get a quick answer:

- **Availity®**
  - **Remittance Advice –** The same electronic remittance advice (ERA) you receive for posting is available in Availity's Remittance Viewer. To view the claims status in your remittance, log in to Availity and select the Claims & Payments Remittance Viewer. If you want to view your legacy remittance, select BlueCross Payer Spaces and click the Print/View Remittance Advice tile.
  - **Claims Status –** To check the status of a claim, log in to Availity and select the Claims & Payments tab, then click Claims Status. An easy way to determine status is to look for the colors associated with the claim: green is processed, yellow is pending and red means denied.

  Note: These steps also apply to outsourced vendors acting on the provider's behalf.
- **Automated Claims Status Option:** You can also get a status update by calling the appropriate Provider Service line and choosing the Automated Claim Status option.

After you've found the status of the claim using one of the above methods, our provider service representatives are still available to answer specific questions you may have about a claim payment or denial. When you're calling to discuss a claim payment or denial, you'll need to provide the specific claim number.

If you have questions or need help with Availity, you can contact eBusiness at **(423) 535-5717**, option 2. If you'd like training on Availity, please contact your eBusiness Regional Marketing Consultant.

Commercial

This information applies to Blue Network P℠, Blue Network S℠ , Blue Network L℠ and Blue Network E℠ unless stated otherwise.

Changes to Genetic Testing Program Prior Authorization

Beginning **March 1, 2023**, CPT® code 84999 won't require prior authorization through eviCore's Genetic Testing Program. However, the following CPT® codes will be added to the Genetic Testing Prior Authorization List and will require prior authorization through eviCore's Genetic Testing Program:

0355U	0357U	0359U	0361U	0363U
0356U	0358U	0360U	0362U	

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

Prior authorization requests can be submitted through Availity, by fax to eviCore at **1-888-693-3210** or by calling **1-888-693-3211**.

New Prior Authorization Requirements for Federal Employee Program (FEP) Members

As of Jan. 1, 2023, some drugs and procedures now require prior authorization for FEP members, including:

- Onpattro®
- Tegsedi®
- Oxlumo®
- Givalaari®
- Vygart®
- Soliris®
- Proton beam therapy
- Stereotactic radiosurgery
- Stereotactic body radiation therapy

You can submit prior authorization request forms to **FEP_Pred@bcbst.com** or by faxing to **(423) 591-9091**. Authorization for provider-administered specialty drugs can be submitted to Magellan Rx through Availity or by calling FEP Customer Service at **1-800-572-1003**. Listen for the specialty drug authorization prompt to connect directly to Magellan Rx.

If you have questions about these updates, please contact FEP customer service at **1-800-572-1003**.

Note: The information in this article only applies to FEP.

New FEP Gender Affirming Surgery Prior Authorization Form Now Available

Providers can now access a new gender affirming surgery prior authorization form for FEP members. Prior to any surgical treatment for gender dysphoria, providers are required to submit this form and list all planned surgeries and the estimated date the procedure will be performed, along with any required documentation. If a treatment plan is approved and later modified, a new form is required.

This form will be available on our **Documents & Forms** site under Authorizations & Appeals. Forms can be faxed to **423-591-9091** or mailed to:

BlueCross BlueShield of Tennessee
Federal Employee Program®
One Cameron Hill Circle
Chattanooga, TN 37402-0017

If you have questions, please contact FEP customer service at **1-800-572-1003**, Monday through Friday, 8 a.m. to 6 p.m. ET.

Quest*Select*™ Program Coming Soon

Beginning early 2023, we're adding the Quest*Select* program for our Marketplace members and members who are part of our AmplifyHealth advocacy program. It'll also be optional for self-funded employer groups.

With this program, members can show their Quest*Select* card at their appointment and request that their provider send their lab work to Quest. This is a voluntary, member-driven program designed to lower member costs for outpatient lab testing. If the member chooses not to use Quest, their normal lab benefits will apply.

The testing must be covered and approved by the member's benefit plan, and the provider or lab technician must indicate Quest*Select* coverage on a Quest Diagnostics requisition that accompanies the specimens to Quest Diagnostics.

Providers can collect specimens in their office and be reimbursed for the collection by submitting a claim with the office charge. Quest Diagnostics will bill us directly for lab testing services.

Call Quest*Select* at **1-800-646-7788** for:

- A faxed copy of the necessary paperwork for your immediate use
- Personalized test order pads for requisitions
- Courier service
- Patient results

If you don't normally collect patient specimens, your patients can call **1-800-646-7788** or visit **QuestSelect.com** to find a Patient Service Center.

BlueCare Tennessee

This information applies to BlueCare℠, TennCareSelect and CoverKids℠ plans unless stated otherwise.

Resources to Support Pediatric Care

We want to make it easy for you to find the information you need to care for your patients with BlueCare or TennCare*Select* coverage. You can find a variety of resources about Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams and your patients' benefits on our website:

- **BlueCare Tennessee Provider Administration Manual (PAM)** – Our PAM is updated quarterly and provides comprehensive information about working with us and our members' benefits.
- **TennCare Kids Tool Kit** – Our TennCare Kids Tool Kit contains information about the TennCare Kids program and links to our EPSDT Provider Booklet, 2022 EPSDT Virtual Training and reference materials for patient outreach.
- **Get a Ride Member Resource** – Here, you can find information about free transportation services that can help patients get to TennCare-covered services. Depending on your patients' plan and location, transportation benefits may include a shared ride, bus pass or mileage reimbursement.

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP) also offers guidance about delivering well-child care, including EPSDT visits and coding. For more information, visit **tnaap.org**.

Note: This information doesn't apply to CoverKids.

Electronic Visit Verification Requirements Take Effect Jan. 1

During 2022, we worked with home health providers to help them comply with 21st Century Cures Act guidelines for electronic visit verification (EVV) use. As of Jan. 1, 2023, all provider agencies delivering in-home services to BlueCare Tennessee members should be using an EVV system to check in and out of member visits.

If you have questions, please contact your Provider Network Manager. We've also included helpful resources in the **Provider Tools and Resources** section of **bluecare.bcbst.com**.

Review Guidance for Administering and Billing Vaccines

Vaccines aren't covered under the pharmacy benefit for your patients with BlueCare, TennCare*Select* and CoverKids plans. Please administer vaccines during office visits instead of referring patients to a pharmacy for care. You can bill vaccine and administration costs to patients' medical benefits using your standard claims process. If the vaccine is provided through the Vaccines for Children program, you can still bill us for administering it.

For more information, please see the **BlueCare Tennessee Provider Administration Manual**.

Expanded Dental Benefits Now Available

The Division of TennCare has expanded dental benefits for patients with Medicaid coverage. As of Jan. 1, 2023, all patients with BlueCare or TennCare*Select* coverage have dental benefits. Previously, benefits were only available to those under age 21, during pregnancy and for 12 months after giving birth.

Please let your patients know about this coverage expansion. If you have questions or would like more information, please visit **bluecare.bcbst.com** or **dentaquest.com**. DentaQuest handles dental care and claims for our BlueCare Tennessee members.

Note: These new benefits don't apply to CoverKids members.

Attest to Closing Gaps in Care for Program Year 2022

The 2022 program year attestation deadline for BlueCare Tennessee Patient-Centered Medical Home (PCMH) and Tennessee Health Link (THL) is Jan. 31, 2023. You can check your attestation status in the **Quality Care Rewards** application within Availity.

For more information about attestable core metrics for the PCMH and THL programs, please see our **Measure Attestation Quick Reference Guide**.

Note: This information doesn't apply to CoverKids.

Stay Up to Date on the Provider Appeals Process

If you disagree with the amount we paid you for a particular claim, you may use our claims reconsideration and appeal process to request a second look. We've put together a few reminders to help make sure reconsideration and appeal requests are processed quickly and correctly. Please note that the below process differs from the process used for utilization management and clinical authorization appeals.

Step 1: Reconsideration – Reconsideration requests must be received within 18 months of the date of the event causing the dispute. Please submit requests for reconsideration, including all supporting medical records, by calling us or filling out the **Provider Reconsideration Form**. **Each form should only include one patient, one claim and one date of service. We can't accept forms for multiple patients or multiple claims.**

Please note that you must file a request for reconsideration before submitting an appeal unless your request is related to a non-compliance denial. A claim may be denied for non-compliance if prior authorization guidelines aren't followed before giving care. You can read more about non-compliance denials and the process for appealing them in our **BlueCare Tennessee Provider Administration Manual (PAM)**.

Step 2: Appeal – An appeal must be received in writing with all supporting medical records within 60 days after receiving the other party's response to its inquiry/reconsideration. Please use the **Provider Appeal Form** to submit appeal requests. Like the Reconsideration Form, each document should only include one patient, one claim and one date of service.

For more information about our claims reconsideration and appeal process, please see the **BlueCare Tennessee PAM**.

BlueCare Plus (HMO D-SNP)SM

This information applies to our Medicare and Medicaid dual-eligible special needs plans.

New Hearing Aid Benefit from TruHearing®

Beginning Jan. 1, 2023, we're offering a new hearing aid benefit through TruHearing that includes access to some of the most advanced hearing aids on the market. Hearing aids can be expensive, especially for some of our D-SNP members and those on a fixed income. We're working with TruHearing to help our members receive one routine hearing exam per year, and up to two TruHearing hearing aids every year (one per ear, per year).

If you have patients with hearing loss asking about hearing aids, please refer them to TruHearing at **1-855-205-6376, (TTY 711)**, Monday through Friday, 8 a.m. to 8 p.m. ET. TruHearing will help them find a qualified network audiologist who will provide a comprehensive exam and talk with them about treatment with hearing aids. TruHearing's Provider Relations team is also available to answer your questions at **1-866-581-9462**, Monday through Friday, 8 a.m. to 8 p.m. ET.

Note: Hearing exams must be performed by a TruHearing provider to be covered.

Updates to Dental Benefits

As of Jan. 1, 2023, your patients enrolled in BlueCare Plus Choice or BlueCare Plus *Select* now have dental coverage through the Division of TennCare Dental Benefits Manager (DBM).

We still cover routine dental services and you can file claims for routine services as you normally would. However, the comprehensive services benefits will now be on a pre-loaded flex card and issued to the member at the start of the plan year (you won't need to file a claim for this charge). Benefit limits and exclusions still apply, and details can be found in the member's evidence of coverage.

If you have questions, please see the **Adult Dental Comprehensive Notice** or reach out to your Provider Network Manager.

BlueCare Tennessee and BlueCare Plus (HMO D-SNP)SM

This information applies to BlueCare℠, TennCareSelect and BlueCare Plus dual-eligible special needs plans.

Southeastrans is Now Verida

Our transportation vendor, Southeastrans, has changed its name to Verida. Even though the name has changed, transportation benefits remain the same. Depending on your patient's plan and location, these benefits may include a shared ride, bus pass or mileage reimbursement.

Your patients with BlueCare Tennessee and BlueCare Plus Tennessee coverage can schedule transportation services by visiting **member.verida.com** or calling the appropriate number for their health plan (these statewide phone numbers haven't changed):

- BlueCare – **1-855-735-4660**
- TennCare*Select* – **1-866-473-7565**
- BlueCare Plus – **1-855-681-5032**

To learn more about your patients' transportation benefits, visit **bluecare.bcbst.com** and select **Get a Ride** or visit **bluecareplus.bcbst.com**.

Note: This article doesn't apply to CoverKids.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ plans unless stated otherwise.

New Over-the-Counter (OTC) Program

Our members now have access to quarterly supplemental benefit credits that allow them to purchase from a catalog of covered over-the-counter health and wellness products. We're working with CVS® to provide this ordering service at no cost to our members. They're eligible for four quarterly benefit credits (amounts vary between $115 and $210 per quarter depending on the member's plan). Quarterly benefits do not carry over from quarter-to-quarter. Items can be purchased in-store or ordered and shipped directly to the member. It's important to note, not all CVS stores accept this benefit and only items listed in the catalog are eligible for purchase. Unused allowance amounts don't carry over from quarter to quarter. Members can view the catalog of eligible items and place an order at **bcbstmedicare.com/otc**, or they can contact us to request a printed copy of the catalog. We recommend members order online or by phone at **1-888-628-2770**.

Member Wellness and Rewards Program

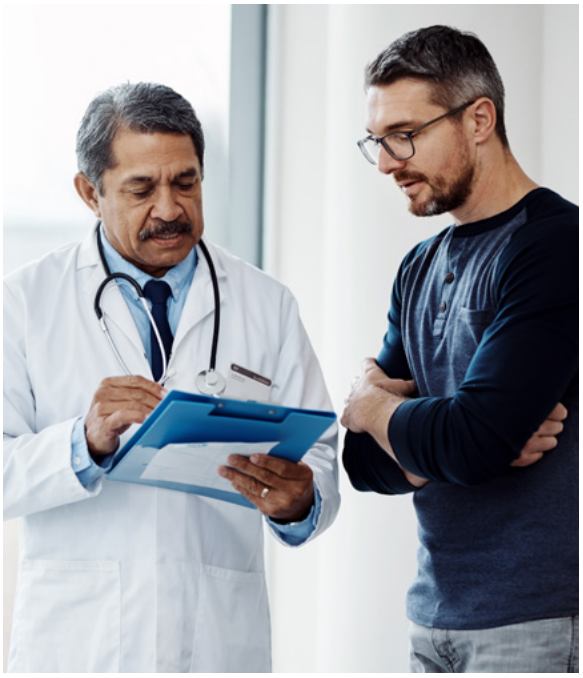
This year, our members are eligible to earn a Walmart® gift card for following healthy behaviors and completing the screenings they need in 2023 through our My HealthPath® Wellness and Rewards program. Members must opt in to participate and can join by calling member service, by logging in at **bcbstmyhealthpath.com**, downloading the **AlwaysOn® Wellness** mobile app or returning the business reply card attached to the 2023 My HealthPath introduction letter mailed to new members.

*Each gift card is restricted and prohibits the purchase of alcohol, tobacco and firearms.

Once enrolled, they're eligible to earn gift cards for certain preventive services. Gift cards are earned once per year for each eligible activity. The date of service must occur within the calendar year. Rewards are available for:

Measure/Activity (Based on Member Eligibility)	Gift Card Amount
Annual Wellness Visit (AWV)	$25
Breast Cancer Screening (BCS)	$25
Colorectal Cancer Screening (COL)	$20 - $50 (depending on type of screening)
Eye Exam for Patients With Diabetes (EED)	$40
Health Needs Assessment (HNA)	$20

For more information about the My HealthPath Wellness and Rewards program, please contact your local Provider Quality Outreach Consultant.



Schedule Annual Wellness Visits for the New Year

Our members are eligible to receive an Annual Wellness Visit (AWV) each calendar year, and the beginning of a new year is a great time to schedule those exams. During the AWV, patients should receive a comprehensive preventive medicine evaluation and management-focused visit. This exam also presents a great opportunity for providers to evaluate, treat and document a patient's chronic conditions and their health status. Chronic conditions and health status codes are very important to assess, document and code at least annually, using the highest level of specificity. While the Z00.xx diagnosis code may be appropriate for the AWV, we encourage providers to document any chronic conditions assessed or treated during the visit as well as adding those conditions to the claim. Any condition that was previously treated and no longer exists can be coded using the appropriate "history of" codes to replace the previously acute or treated condition(s).

2023 Quality Program Measures

We've made some changes to the quality measures included in the Quality+ Partnerships 2023 program:

- **The Kidney Health Evaluation for Patients with Diabetes (KED)** measure and the **Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)** moved from the monitoring section of the program into the scored section of the program as single-weighted measures.
- The **Member Experience – CAHPS** measure moved from a weight of two to a weight of **four**.
- The **Comprehensive Diabetes Care (CDC) A1C and Eye Exam** measure names update to **Hemoglobin A1C Control for Patients with Diabetes (HBP)** and **Eye Exam for Patients with Diabetes (EED)**.

The 2023 program year measures are listed in order of measure weight:

Measure	Source	Weight
Member Experience - CAHPS	CMS Member Survey	4
Controlling High Blood Pressure (CBP)	HEDIS®	3
Hemoglobin A1c Control for Patients with Diabetes (HBP)	HEDIS®	3
Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) Files	3
Medication Adherence for Hypertension (RAS Antagonists)	Prescription Drug Event (PDE) Files	3
Medication Adherence for Non-Insulin Diabetes Medications (OAD)	Prescription Drug Event (PDE) Files	3
Plan All-Cause Readmissions (PCR)	HEDIS®	3
Member Experience (HOS)	CMS Member Survey	2
Breast Cancer Screening (BCS)	HEDIS®	1
Colorectal Cancer Screening (COL)	HEDIS®	1
Eye Exam for Patients with Diabetes (EED)	HEDIS®	1
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)	HEDIS®	1
Kidney Health Evaluation for Patients with Diabetes (KED)	HEDIS®	1
Osteoporosis Management in Women Who Had a Fracture (OMW)	HEDIS®	1
Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy (SPC)	HEDIS®	1
Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) Files	1
Transitions of Care (TRC)	HEDIS®	1

Note: These changes won't be reflected in the Quality Care Rewards (QCR) application until mid-February. Contact your Provider Quality Outreach Consultant if you have questions about the measures included in the 2023 quality program.

Pharmacy

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

Reminder: Restrictions for Opioids

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

These restrictions were implemented in 2019 and will continue through 2023:

- Pharmacies will receive a safety edit when members are prescribed more than 90 morphine milligram equivalents (MME) by two or more prescribers. The pharmacist can override this edit at point of sale.
- Opioid-naïve members are limited to seven days for their initial fill
- Members prescribed more than 200 MME by two or more prescribers will automatically reject and may require a coverage review.
- Concurrent use of long-acting opioids is restricted.
- Concurrent use of opioids and benzodiazepines is restricted

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

Note: These will reject at point-of-sale. In certain situations, the pharmacist at point-of-sale may be able to override these rejections. If not, a coverage determination will need to be requested if the member needs to continue the medication as prescribed.

You can find more information about these Medicare Part D Opioid Overutilization Policies **here**.

In addition to the above restrictions, we require prior authorization on all long-acting opioid medications. All opioids have a quantity limit restriction applied. You can **find our drug lists** and **prior authorization criteria** online.

To request prior authorization or coverage determination for your patients, contact:

BlueAdvantage
Phone: **1-800-831-2583**
Fax: **(423) 591-9514**

BlueCare Plus
Phone: **1-800-299-1407**
Fax: **(423) 591-9514**

Medical Exclusion Updates

This year, we've implemented a medical exclusion option for medication therapies covered under the Commercial Provider Administered Medical Benefit. After completing a clinical review, some products may be moved to excluded status and not be covered for Commercial members. Provider administered pharmacy products excluded from coverage can be found on our medical exclusion drug list.

Asceniv™ is excluded from coverage for Commercial members as of January 2023. Members are encouraged to discuss covered options with their provider if using one of our excluded products. If members choose to remain on an excluded product, benefits may not apply, and the member may be responsible for the entire cost of the drug therapy.

Note: This information only applies to Commercial members.

Refer to the TennCare Pharmacy Benefit Manager for Important Updates

Please **click here** to review important notices about prescribing changes, authorization guidelines and other items related to the TennCare Pharmacy Program.

Tips for Coding Professionals

This information applies to all lines of business unless stated otherwise. Please note these tips are educational only, providers remain responsible for completion of claims submitted to BlueCross.

Billing for Molecular Diagnostic Tests with Unlisted Codes

When billing molecular diagnostic tests with unlisted codes:

- Components of the tests with specific codes should be billed with the most appropriate code.
- All components of a test with no specific code should be included on a single line and billed with the most appropriate unlisted code. Information should be submitted to identify these remaining components.
- When billing a registered DEX™ Diagnostics Exchange test with an unlisted code, **both** the full name of the test and the **LAB/MFR TEST ID** number must be submitted for review.

If you have questions about this change, reach out to your Provider Network Manager.

Coding Updates: See the Latest and What Changes Are on the Way

You can easily find current coding updates and pending claim edit changes under **Coding Updates** in the Coding Information section of our Coverage & Claims page. You can access code edits 60 days before the effective date. If you have questions, please call us at **1-800-924-7141** and follow the prompts for providers (option 1).

BlueCross BlueShield of Tennessee, Inc., BlueCare Tennessee and their licensed health plan and insurance company affiliates comply 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 TennCare*Select*. For TTY help call **771** and ask for **1-888-418-0008**.

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, Inc. or any of its licensed affiliates. 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.

Archived editions of BlueAlert are available **online.**

Contact Us Through Availity

Availity® makes it easy for you to do business with us online anytime, offering faster prior authorizations, claims decisions and more. You can log in at **Availity.com** to:

- Check benefits, eligibility and coverage details
- Manage prior authorizations
- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
- Manage your contact preferences

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

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 Plus℠	1-800-299-1407
***Select*Community**	1-800-292-8196
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	1-800-924-7141
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)	

Important Note:

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

Please visit the BCBST payer space at **Availity.com** and update your information.

Update your provider profile on the **CAQH Proview®** website.

Questions? Call **1-800-924-7141**.