of Tennessee

MAY 2023

BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

A monthly newsletter for our provider community, featuring important updates and reminders about our company's policies and procedures. All information is broken out by line of business.

BlueCross BlueShield of Tennessee, Inc.

This information applies to 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. With the National Public Health Emergency ending on May 11, 2023, we'll be taking steps to return to some of our original policies and procedures. Please continue to visit the Provider FAQs at **bcbstupdates.com** for up-to-date guidelines to help you care for our members.

INSIDE THIS ISSUE

Avoid Delays with the Group Enrollment Form

Understanding our network participation enrollment process provides a more efficient experience for providers. Providers with only an Entity Type 1 National Provider Identifier (NPI) should use the Provider Enrollment Form (PEF). If a provider has an Entity Type 2 NPI, in addition to their individual Entity Type 1 NPI, a Group Enrollment Form (GEF) must be submitted to avoid any delays in the enrollment process. For example, an individual (Type 1 NPI) joining a group (Type 2 NPI) must complete and submit a GEF. Click **here** for the Centers for Medicare & Medicaid Services' definitions of Entity Type 1 and Entity Type 2.

The GEF allows up to 15 practitioners per application, and we pre-populate many fields to save time for the applicant. You can find the PEF and GEF on Availity® under the **Provider Enrollment, Updates and Changes** tile.

In March, we began rejecting PEFs for individual providers if the provider belongs to or joins a group with a Type 2 NPI.

If you have questions or need help with the enrollment process, reach out to your **Provider Network Manager**.

Be on the Lookout for Our Updated Network Verification Form

We've updated the Network Verification Form to make it easier to identify providers who perform certain services. You can now let us know if your group contracts with these provider types:

- Lactation consultants
- Doulas
- Dietitians/nutritionists
- Certified Diabetes Care and Education Specialists

Our goal is to help better connect our members with the services they need, so please update your information and let us know if members can receive lactation, diabetes care, doula or nutrition support in your office.

Updates to Find My BlueCross Contact

We want to make it as easy as possible for you to work with us, so we've made a few updates to the **My BlueCross Contact page**. Now when you visit the page and type your information into the search box, you'll find detailed explanations about who to contact:

- For questions about an existing contract, you'll be directed to our Provider Contracting team via a drop-down menu based on region.
- For non-contracting questions, you'll be directed to your assigned Provider Network Manager.

For all other provider service-related questions, please call our Provider Service line at **1-800-924-7141**.

Providers Must Register for Electronic Funds Transfer

As of September 2022, 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 currently receiving electronic payments and remittance advice as intended, 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 contact your Provider Network Manager.

Commercial

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

Provider Satisfaction and Wait Time Surveys Coming Soon

Providers participating in the Commercial and Marketplace Blue Networks P℠, S℠, L℠ and E℠ will receive our 2023 Provider Satisfaction and Wait Time surveys between June and September. We encourage you to take time to share your feedback when you receive the surveys.

Save Time by Verifying Home Health and Outpatient Therapy Services Benefits

Not all home health and outpatient therapy services require a precertification, and you can save time by verifying the patient's benefits in **Availity** before submitting a request.

If you do obtain a preauthorization for these services and it's no longer necessary or need to adjust the number of visits or timeframe, please let the preauthorization department know by submitting a clinical update through Availity or call us at **1-800-924-7141**.

Obstetric Anesthesia Must Be Billed on Single Claim Form

Obstetric anesthesia for a planned vaginal delivery (01967) that ends in a caesarean section (01968) must be billed on a single claim form using the date of delivery as the date of service. Add-on codes are always performed in addition to the primary service or procedure and should never be reported as a stand-alone code on a separate claim. Add-on codes submitted with no primary code or a different date of service result in rejection and non-payment of the add-on code.

In cases with obstetrical anesthesia for the planned vaginal delivery beginning on one day and the actual caesarean section on the following day, dates of service for both codes should have the same "from and through" date (i.e., from beginning of anesthesia through to the completion). Obstetric anesthesia services involving more than one provider (e.g., two physicians or two certified registered nurse anesthetists) for the same episode must be submitted on a single claim, under one NPI, with the date of delivery as the date of service. Separate claims for multiple providers will result in denial for the add-on code.

Changes to Genetic Testing Program Prior Authorization

Beginning **June 1, 2023**, the following codes will be added to the Genetic Testing Prior Authorization List and require prior authorization through the EviCore Genetic Testing Program:

0364U	0369U	0374U	0379U	0384U
0365U	0370U	0375U	0380U	0385U
0366U	0371U	0376U	0381U	0386U
0367U	0372U	0377U	0382U	
0368U	0373U	0378U	0383U	

These two codes will be removed from the EviCore Genetic Testing Prior Authorization List:

- 0324U and 0325U (3D Predict tests)

The following codes will have revised code descriptions:

- 0022U: Revised to remove the cholangiocarcinoma indication for Oncomine™ DX Target testing
- 0095U: Had inconsequential wording edits

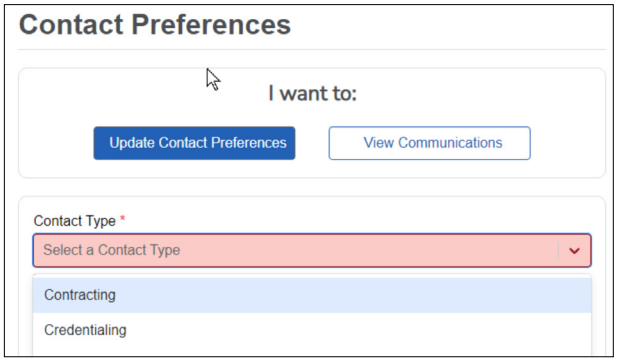
Get Contracts and Fee Schedule Updates Quicker

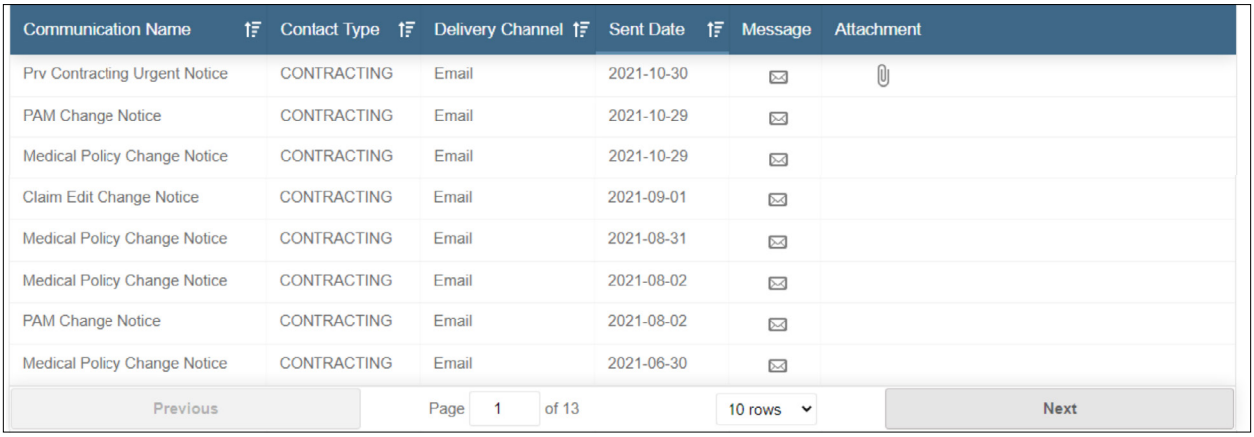
You can receive contract-related communications – including fee schedule updates – up to three days faster by switching from mail to email. Simply update your **Contact Preferences** through our Payer Spaces in Availity and make email your preferred **contracting** communication type. Here's how:

1. Log in to **BlueCross** Payer Spaces.
2. Select the **Contact Preferences & Communication Viewer** tile.
3. Choose **Contracting** as your **Contact Type** and then your **Organization** (based on Tax ID Number).
4. Verify your **Provider Name** and **National Provider Identifier (NPI)** and click **Submit**.
   - For the **Contracting contact**, you may have multiple provider names in the left pane, so select the name(s) you want to update.
   - If you don't see your name in the drop-down list, add your provider through the **Manage My Organization** dashboard.
5. Follow the remaining cues, including checking the email **Opt-In** box and making sure email is the first option in the **Communication Preference** list on the right side. Then, click **Save & Submit**.

   You can apply the same updates to other contact types by checking additional **Contact Type** boxes – or the **Select All** box.

You can also view a record of past email communications by clicking the **View Communications** button from the **Update Contact Preferences** screen.





Communication Name	Contact Type	Delivery Channel	Sent Date	Message	Attachment
Prv Contracting Urgent Notice	CONTRACTING	Email	2021-10-30		
PAM Change Notice	CONTRACTING	Email	2021-10-29		
Medical Policy Change Notice	CONTRACTING	Email	2021-10-29		
Claim Edit Change Notice	CONTRACTING	Email	2021-09-01		
Medical Policy Change Notice	CONTRACTING	Email	2021-08-31		
Medical Policy Change Notice	CONTRACTING	Email	2021-08-02		
PAM Change Notice	CONTRACTING	Email	2021-08-02		
Medical Policy Change Notice	CONTRACTING	Email	2021-06-30		

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From the **Communication Name** list, you can click the envelope icon ✉ (**Message** column) to download the actual message. If a paper clip icon 📎 is displayed in the Attachment column, you can download the attachment that was included with that message.

For more information about Contact Preferences, please refer to the *Contact Preference Quick Reference Guide* under the **Payer Spaces Resources** tab in Availity. If you need help accessing your fee schedules for BlueCross contracts, you can also find a *Fee Schedule Viewer Quick Reference Guide (QRGs)* under the **Resources** tab.

If you have questions, contact our eBusiness Service team at **(423) 535-5717 (option 2)**. Or, you can call the Provider Service line at **1-800-924-7141** and follow the prompts to **Contracting and Credentialing**.

BlueCare Tennessee

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

BeHiP Program Offers Behavioral Health Care Resources for Pediatric Providers

We want to share a friendly reminder that we're working with the Tennessee Chapter of the American Academy of Pediatrics (TNAAP) to provide the Behavioral Healthcare in Pediatrics (BeHiP) training program for pediatric health care providers. The BeHiP program is designed to equip providers with tools to screen for, assess and manage patients with emotional, behavioral and substance use concerns. It also covers coding and offers strategies for delivering more effective care and improving family and physician relationships.

Program objectives include:

- Applying principles of systems-based practice to behavioral health disorders in the primary care pediatric setting.
- Demonstrating ways to screen, assess and treat behavioral health concerns.
- Developing office-based protocols to improve communication and collaboration with the behavioral health system of care.

Pediatric providers can request virtual or in-person office-based training conducted by TNAAP BeHiP staff or complete online learning modules. Both types of training are free, and continuing education credits are available. Providers in our BlueCare, TennCare*Select* (including the Best Practice Network) and CoverKids networks may also be eligible to join the BeHiP Foster Care Learning Collaborative as a Best Practice Network Provider. The learning collaborative consists of Best Practice Network Providers, psychiatrists and psychologists, Department of Children's Services nurses and staff, BeHiP staff, and community behavioral health providers. The group meets virtually every month and uses case-based learning to discuss how to address behavioral health issues in children in foster care.

For more information, visit **tnaap.org/programs/behip/behip-overview/**. If you'd like to schedule training for your practice, please call Elaine Riley, M.A., BeHiP Program Manager, at **(615) 653-6276** or email **Elaine.Riley@tnaap.org**.

Lactation Consultant Benefits Effective June 1

We're working with the Division of TennCare and the other TennCare managed care organizations to help ensure parents get the support they need to successfully breastfeed. Beginning **June 1, 2023**, your patients enrolled in BlueCare, TennCare*Select* or CoverKids will have lactation consultation benefits.

Our members' benefits include medically appropriate lactation consultation services from in-network providers during pregnancy and after birth. Parents can receive services through telehealth or in-person in a one-on-one or small group setting, and there's no limit on the number of visits allowed during pregnancy and through the extended postpartum period or for as long as medically necessary.

In-network International Board-Certified Lactation Consultants (IBCLCs) and contracted providers with lactation counseling, education or consultation within their scope of practice can bill for lactation services. Certified Lactation Counselors and Certified Lactation Educators may also provide lactation support when services are supervised and billed by a registered, in-network provider.

Learn More about the Benefit

The Division of TennCare is hosting a webinar on July 11 to share more information about this new benefit with lactation professionals. Please watch for more information, including dates, times and links to join the virtual event, coming soon.

If you have questions about billing and coding lactation services, please call the Provider Service line for your patient's plan:

- BlueCare – **1-800-468-9736**
- TennCare*Select* – **1-800-276-1978**
- CoverKids – **1-800-924-7141**

Help Your Patients Stay Up to Date with Preventive Care

It's not always easy to keep children on track with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams. Consider these tips to make scheduling easier for your patients – and your practice:

- Schedule a full year of visits for newborns during their first visit. This not only helps new parents plan for upcoming visits, but also keeps a plan of care in place if a visit is missed. For children 2 years and older, schedule the next well-child exam at the end of each appointment. Children and teens covered by BlueCare Tennessee are eligible for well-care visits on the same schedule recommended by the American Academy of Pediatrics.
- Make the most of your patient reminder tools, such as letters, text messages and reports.
- Use our Quality Care Rewards application to view a list of patients past due for preventive services.
- Consider offering extended or alternate office hours to make it easier for families to keep appointments. Some practices have found that offering appointments in the evenings or on weekends helps more kids and teens get their checkups. If you're interested in adjusting your hours, ask your patients' parents and caregivers what times are most convenient for them.

Note: This article doesn't apply to CoverKids.

Billing Requirement for Physical, Occupational and Speech Therapy Services

According to CMS guidelines, physical, occupational and speech therapy services are defined 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, professional claims submitted for these therapy services without the ordering or referring provider listed will be rejected.

If you have questions about this requirement, see the **Electronic Code of Federal Regulations website**.

Update Your Patient's Assigned Primary Care Provider in Availity

As part of our ongoing effort to support the myBluePCP program and encourage strong provider-patient relationships, you can now change patients' assigned primary care providers (PCPs) in Availity. The **BlueCare PCP Maintenance** application is intended to replace the current PCP change form process outlined in the BlueCare Tennessee Provider Administration Manual.

Using the BlueCare PCP Maintenance application means that PCP changes will be completed in real time. New member ID cards will be mailed to members as soon as the change is made, and digital ID cards will be available immediately in each member's **BCBSTN** mobile app. We expect this update to make our processes significantly more efficient and improve the turnaround time of PCP changes.

For step-by-step instructions for using the application, please review our **BlueCare Tennessee and CoverKids PCP Change Maintenance Application Quick Reference Guide** located in the **Resources** section of **Availity Payer Spaces**. If you have other questions or would like training on using Availity, please contact your **eBusiness Regional Marketing Consultant**.

Make Sure Your Patients Are Ready for Medicaid Reverification

TennCare started the reverification process for Tennesseans with BlueCare, TennCare*Select* and CoverKids coverage on April 1. Over the next year, TennCare will review each member's eligibility to continue receiving benefits.

To help make sure your patients don't experience a gap in coverage during this process, please encourage them to:

- Sign up for **TennCareConnect**, the state's free, online portal. There, they can select how they want to receive communications (text, email or mail) about their benefits
- Verify their contact information in TennCareConnect or by calling **1-855-259-0701**
- Open and respond to all mail from TennCare

For more information, please visit TennCare's **Preparing for Renewals web page**.

Expanded Dental Benefits Now Available

TennCare has expanded dental benefits for patients with Medicaid coverage. Effective Jan. 1, 2023, all patients with BlueCare or TennCare*Select* coverage have dental benefits. Previously, benefits were only available to members:

- Under the age of 21
- Who are pregnant (and for 12 months after giving birth)
- Who enrolled in Employment and Community First CHOICES or a 1915(c) waiver

Please let your patients know about this coverage expansion. If you have questions or would like more information, 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.

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, 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**.

Provider Satisfaction Survey Coming Soon

Providers in the BlueCare and TennCare*Select* networks will receive our 2023 Provider Satisfaction Survey between June and September. When you receive the survey, we hope you'll take the time to share your feedback. We look forward to hearing from you.

To learn more about the survey and how you can participate, please read the Division of TennCare's survey letter, which you can find on the **News and Manuals Provider page** under the **Announcements** header.

BlueCare Plus (HMO D-SNP)SM

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

Outpatient Procedure Code 64640 Will Require Prior Authorization

Effective **June 1, 2023**, outpatient procedure code 64640 (destruction by neurolytic agent; other peripheral nerve or branch) will require prior authorization. Requests should be submitted through Availity. If you have questions about this change, please contact Utilization Management at **1-866-789-6314**.

2023 Special Needs Plan Model of Care (MOC) Training Now Available

Providers participating in BlueCare Plus special needs plans are contractually required to complete our MOC training after initial contracting, then every year after. This training promotes quality of care and cost effectiveness through coordinated care for members with complex, chronic or catastrophic health care needs. You can access the online self-study training and attestation by **clicking here**.

Medicare Advantage

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

Palliative Care Management Program for Members in Middle Tennessee

As part of our continuous focus on improving the member experience, we're working with **Amedisys, Inc.** to establish a **palliative care management program** for members located in **Middle Tennessee**.

Amedisys can help your patients manage their health conditions with comprehensive care in their home. They provide individuals and their families with support that focuses on improving quality of life. With this program, your patients can call or be seen at home by Amedisys' team members including doctors, nurse practitioners and nurses at no additional cost. A dedicated team will be available by phone 24 hours a day, seven days a week.

You can refer your patients to Amedisys by calling **(615) 314-3501**. Our members may also self-refer if that's their preference. If you have questions, please call our Provider Service line at **1-800-924-7141**, Monday – Friday, 8 a.m. to 6 p.m. ET.

Change in Criteria for Advanced Illness and Frailty Exclusions

Previously, to qualify for a frailty exclusion, patients needed at least one claim with a frailty diagnosis or treatment code. This year, patients must have at least two claims on different dates of service with a frailty diagnosis or treatment code. Coding for Advanced Illness and Frailty on claims can remove some patients from the denominator for certain measures, which can help increase your Stars score. The two indications on different dates of service don't have to be for the same frailty diagnosis.

If you have questions or need to request a copy of the 2023 Advanced Illness and Frailty guide, please contact your Provider Outreach Consultant.

Changes to the Kidney Health Evaluation for Patients with Diabetes (KED) Measure

Shortly after we released our 2023 measures, CMS changed the KED measure to "monitoring status only." The measure was added to the 2023 scorecard this year with a weight of one and was removed from the monitoring section of the scorecard with the QCR application refresh on March 30.

While this measure may not be a priority this year, we recommend continuing to monitor the status of your patients in the denominator. We expect KED to be a weighted measure for 2024. If you have questions, please contact your Provider Outreach Consultant.

New Electronic Provider Assessment Form Bulk Download Feature

Electronic Provider Assessment Forms in the QCR application can now be exported in bulk. To download multiple forms, click on the **Assessments** tile in the QCR. A list of your patients will appear with a box next to their name. **Check the boxes** for the forms you want to export, then click the blue **Export** button above the list. The forms will download in a ZIP file that will appear at the bottom of your screen. Click on the tab to open the file and access the forms you exported.

If you have questions, please contact your Provider Outreach or eBusiness Consultant.

Nonstandard Provider Assessment Forms Discontinued in 2024

Beginning in 2024, only Electronic Provider Assessment Forms (ePAFs) will be accepted. These forms can be billed with the same CPT® code 96161 and reimbursed at $225. You can complete the ePAFs electronically in the QCR application or export and complete them by hand and upload them to the QCR or fax them.

If you have questions, please contact your Provider Outreach Consultant.

100-Day Supply of Tier 1 Preferred Generic Medications

All Medicare Advantage members, no matter which plan, can now receive a 100-day supply of Tier 1 preferred generic medications. If this is a feasible option for your patient, simply indicate on the prescription that the medication is for a 100-day supply. Pharmacies are unable to increase the quantity of a 90-day prescription to 100 days, so without this step, your patient won't receive an increased quantity. Copays are outlined below:

- 100-day supply of Tier 1 preferred generics at preferred retail pharmacies or mail order pharmacies
  - Copay $0
- 100-day supply of Tier 1 preferred generics at standard retail pharmacies
  - Copay $15

To meet compliance in the medication adherence measures, members must fill their prescriptions often enough throughout the year to have coverage 80% of the time they're supposed to be taking the medication. With a 100-day supply, members will require fewer fills to achieve compliance.

Note: If the pharmacy receives a prescription with a quantity of 100 for a medication that doesn't qualify for this benefit (a non-preferred generic), the pharmacy will simply reduce the quantity to the appropriate 30/60/90-day supply without the need to contact the provider office for approval.

New Over-the-Counter Program

Medicare Advantage members have access to a new over-the-counter program. This program provides a fixed dollar amount each quarter to buy over-the-counter medications and select products (e.g., bandages, pain relievers, cold medicine, antihistamines or toothpaste). The available allowance depends on the member's plan, ranges from $100 to $200 quarterly and doesn't carry over to the next quarter.

To use their allowance, members can simply present their ID card at qualifying CVS store check-outs. No additional card is required for approved items. When approved items aren't available in-store, **cvs.com/otchs/bcbstma** is the recommended option to find supplies.

If your patients are interested in using this program, they can request to have a catalog mailed to them (one per member per contract year) by calling **1-888-628-2770, TTY 711**.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage (PPO)℠ and BlueCare Plus (HMO D-SNP)℠ plans unless specifically identified below.

Step Therapy for Additional Medicare Part B Drugs

Effective **May 1, 2023**, BlueAdvantage and BlueCare Plus are implementing step therapy for additional Part B drugs. This affects members who are new to therapy. Prior authorization and step therapy follows CMS regulations and is required for the following Part B drugs:

- Alymsys®
- Byooviz™
- Cimerli™
- Colony Stimulating Factors (Pegfilgrastim and Rolvedon™)
- Vegzelma®
- Vivimusta™

If you have questions, you may view our **Part B Step Therapy Provider Reference Guide** or contact your Provider Service Team for more information.

Pharmacy

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

New Prior Authorization Requirement

Beginning July 1, 2023, we will add a new prior authorization requirement for glucagon-like peptide-1 (GLP-1) receptor agonists to confirm diagnosis for the Commercial/Preferred drug list. Members are also subject to the current quantity limits.

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.

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 (option 1)** and follow the prompts for providers.

Quality Care Rewards

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

Tennessee Health Care Innovation Initiative Episodes of Care Program Reports Available This Month

Quarterbacks participating in the Episodes of Care Program will receive their 2023 Interim Performance Reports for our BlueCare and Commercial lines of business on May 18. Please log in to **Availity** to review your reports.

If you have trouble accessing your reports in Availity, please call **(423) 535-5717** and choose **option 2**, or email **eBusiness_Service@bcbst.com** for assistance.

Note: This article applies to Commercial and BlueCare.

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**.