JANUARY 2024

BlueAlert℠

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 made changes to help our members and providers stay safe. Now that the National Public Health Emergency has ended, we're 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

Understanding Our Members' 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. They also help us comply with regulatory and accreditation requirements. For your convenience, we publish our current member rights and responsibilities in our **Provider Administration Manuals**.

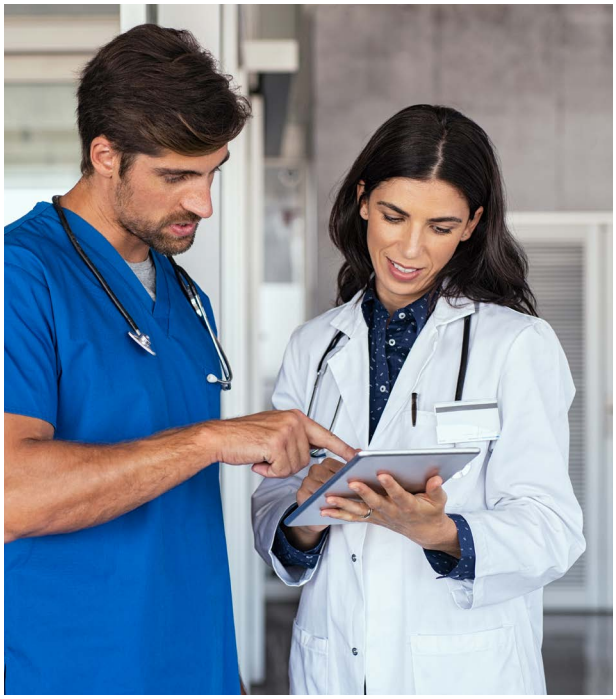
Provider-Administered Specialty Drug Prior Authorizations Changes Now Active

Effective **Jan. 1, 2024**, we're no longer using MagellanRX for provider-administered specialty drug prior authorizations. Instead, we're processing these authorizations internally.

The authorization decision and appeal process hasn't changed. The line-of-business-specific appeal processes are included on each authorization notification letter.

Please continue to submit Specialty Pharmacy Prior Authorizations in our **payer space** on Availity® for a more streamlined process and to receive a faster response. Often, online authorization submission will be instantly reviewed.

Please reach out to your **eBusiness Marketing Consultant** for your Availity questions or training needs.



Referring Out-of-State Providers to Availity

As a reminder, all contracted providers are required to go to Availity for eligibility and benefits status – not to our Provider Service Line.

Previously, out-of-state providers could call our Provider Service line to obtain benefits and eligibility information. However, as of Dec. 1, 2023, we're requiring all out-of-state providers who are contracted with BlueCross to verify benefits through **Availity.com**.

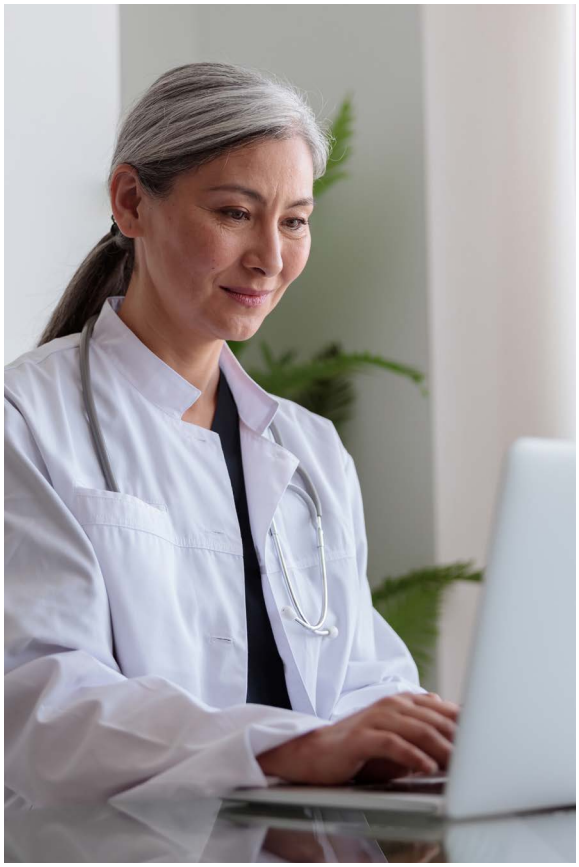
With Availity, you can get the answers you need 24 hours a day, seven days a week. To check eligibility and benefit information, simply log in to Availity and click **Patient Registration**, then **Eligibility and Benefits Inquiry**.

If your office needs help getting started with Availity, contact your **eBusiness Marketing Consultant** for training and education.

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.

Digital Member ID Cards Coming Soon in Availity

Member ID cards will soon be available in Availity. You'll be able to view and print Member ID cards, which are located under the **Eligibility and Benefits** tab. If you have Availity questions or training needs, contact your **eBusiness Marketing Consultant**.



Help Prevent Coordination of Benefits Denials

You can help prevent coordination of benefits (COB) denials on claims by reviewing **Eligibility & Benefits** in Availity to determine if the COB has been updated within the past 12 months. If the COB information hasn't been updated, we recommend you have the member complete the entire COB questionnaire and fax it to the number at the top of the questionnaire. This allows us to update the COB information and process the claims.

The forms are located at the following links in both English and Spanish. You can also find the **questionnaire** in **Availity's Payer Spaces** under the **Resources** section. Simply look for the word **Forms** under the **Resources** tab.

- **English Form**
- **Spanish Form**

Note: It's important that the member completes the entire COB form. An incomplete form will prevent us from updating their information.

Submit High Tech Imaging Authorizations through Availity

High Tech Imaging (HTI) authorizations for Commercial and BlueCare Tennessee members should be submitted through Availity. During the authorization process, you'll be transferred to the eviCore website, where you can complete the authorization. It's not necessary to go to the eviCore website or to call eviCore directly to obtain your authorization. You can find a **High Tech Imaging Quick Reference Guide** with step-by-step instructions to help you request initial authorizations for HTI services in the **Resources** section of **Availity's Payer Spaces**.

New Providers Must Register for Electronic Funds Transfer with Change Healthcare

New providers must register for Electronic Funds Transfer (EFT) with Change Healthcare before we can enroll them in our network. As of Oct. 11, 2023, we began requiring a **completed** and **approved** application with Change Healthcare before accepting a request for enrollment through Availity.

To sign up, please use Change Healthcare's Payer Enrollment Services portal at **payerenrollservices.com**.

Please note:

- You'll need to allow up to 10 days to receive approval from Change Healthcare.
- Attempts to enroll new groups or providers that don't already have an established EFT record on file with us will be rejected.
- Once you receive your approval confirmation, please go to our Availity **Provider Enrollments and Changes** section to complete your enrollment process.
- For questions about the progress of your Change Healthcare application, you can visit **payerenrollservices.com**.

If you're already an in-network provider and currently receive 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 eBusiness 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 Prior Authorization for Commercial Plans

Beginning **Feb. 1, 2024**, the following codes will be added to the Genetic Testing Prior Authorization List and will require prior authorization through the eviCore Genetic Testing Program.

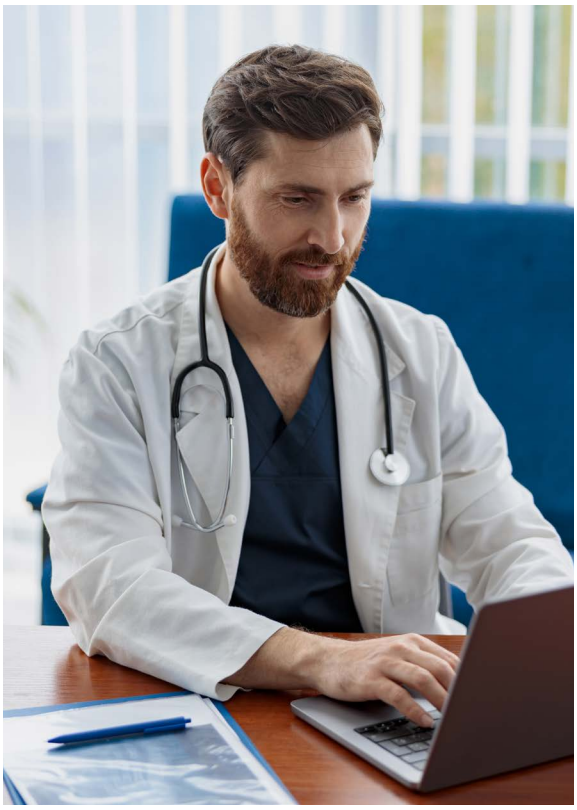
0420U	0423U	0426U	0434U
0421U	0424U	0428U	0437U
0422U	0425U	0433U	0438U

Authorization Policy for Applied Behavioral Analysis

This is a reminder that Applied Behavioral Analysis is a non-urgent service according to our policies. As a non-urgent service, it must be authorized at least one business day prior to admission or no later than one business day post admission.

Failure to comply within specified authorization timeframes may result in a denial or reduced benefits due to non-compliance. Contracted providers can't bill members for covered services that are denied due to non-compliance by the provider.

To arrange routine behavioral health services, call **1-800-924-7141**, fax **1-800-496-9600** or submit your authorization requests through Availity.



New Law for Tennessee Heartbeat Bill Requires Attestation

Gov. Bill Lee signed a new law on April 28, 2023, providing limited exceptions to the Tennessee Heartbeat Law that was passed in 2020.

For us to process these claims, providers are required to attest an abortion was performed according to applicable state and federal law. When submitting this type of claim, please complete and fax the following forms the same day as your claim to **(423) 591-9481**:

1. The Provider Attestation for Abortion Services form, located under **Authorizations & Appeals** on the **Provider Forms** page of **provider.bcbst.com**.
2. The **PWK Fax Cover Sheet**, which is also posted on the Provider Forms page.

Payment will be denied if the required forms are not included with these claims.

If you have questions, please call our Specialized Pregnancy line at **1-866-268-3502**.

BlueCare Tennessee

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

Process Change for Medicare Crossover Claims

Effective **Jan. 1, 2024**, we're processing Medicare and Dual Special Needs Plan (DSNP) crossover claims. Previously, the Division of TennCare processed these claims for the Medicare and DSNP coinsurance and deductible amounts.

Moving forward, for all claims with a date of service of Jan. 1, 2024, and beyond, providers will no longer need to submit a secondary claim for Medicare or a DSNP. Providers can submit one claim to Medicare or the member's DSNP. That claim will automatically cross over to us, and we'll process the coinsurance and deductible amounts using pricing methods defined by the Division of TennCare. We'll also process any remaining Medicaid-covered services.

Please note: All prior authorization requirements, timely filing guidance and payment amounts will remain the same, and TennCare will continue to process all claims with a date of service before Jan. 1.

If you have questions about this process change, please call the **Provider Service line** for your patient's plan.

THCII Episodes of Care Program Updates

As we move into the 2024 Performance Year for the Tennessee Health Care Innovation Initiative (THCII) Episodes of Care Program, please take a moment to review the **Division of TennCare's 2024 Episode Changes memo**. The memo includes TennCare's response to stakeholder feedback, along with a summary of program changes for the new year.

Additionally, TennCare has posted cost-savings results from the 2022 calendar year, which you can view **here**. As a reminder, providers participating in BlueCare Episodes of Care received their payments based on 2022 results on **Dec. 12, 2023**, and you can review your payment amount and final reports in Availity.

Medline DMEPOS Supplier Services Transitioning to Home Care Delivered, Inc.

Home Care Delivered, Inc. has acquired Medline, our sole provider for incontinence supplies. Medline sold its durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) assets to Home Care Delivered, Inc. in 2023 and is winding down operations.

Beginning **Feb. 1, 2024**, we'll be transitioning members currently getting services from Medline to Home Care Delivered. We'll share more information soon about the transition process for active and new orders.

Lactation Information for Your Patients

We've developed posters about lactation consultant benefits for our network providers to display in their offices. Two versions are available – one for obstetrics provider offices and one for pediatric/primary care offices – and the posters display important information, including:

- Covered lactation consultant services
- Reasons to see a lactation consultant during pregnancy and the postpartum period
- How to order a free breast pump
- Resources for mental health support

Each poster is available in English and Spanish, and providers can request copies at no charge. To order copies for your office, please email **Provider_Communication_Requests@bcbst.com**.

Review Our Intellectual and Developmental Disabilities Tool Kit

We know living with or caring for someone with an intellectual and developmental disability (IDD) can be challenging. So, we've developed a **tool kit** for our members and their families to make finding information and connecting with community resources easier. It includes information about diagnosis and living with an IDD, links to community organizations, and helpful details about transportation benefits, our care team and more.

Please review the tool kit and let your patients and their families know it's available. We hope you find it useful.

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, 2023 EPSDT Virtual Training and references for patient outreach.
- **Get a Ride Member Resources** – Here, your patients will find information about transportation services, including scheduling. Your patients' benefits include transportation to and from TennCare-covered services and the pharmacy. Depending on their location within the state, transportation options 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: The information in this article doesn't apply to CoverKids.

Use Availity to Change Members' Primary Care Provider

In May 2023, we launched the **BlueCare Primary Care Provider (PCP) Change Maintenance** application in Availity. You can read more about the application in the **May, June and July 2023 BlueAlert newsletters**.

The application has been successful, averaging 200-300 PCP changes daily. Due to its success, we're phasing out the existing **PCP Change Request Form**. Beginning **April 1, 2024**, providers will need to use the **BlueCare PCP Change Maintenance** application to change the PCP assignment for a member with BlueCare, TennCare*Select* or CoverKids coverage.

Please note: This only affects the PCP change process providers use. Our members can still change their PCP by calling the Member Service line or through their member online account.

As a reminder, when you use the application, changes are made in real time. New ID cards are mailed to members automatically as soon as the change is made, and digital ID cards are available immediately in the **BCBSTN** mobile app. For step-by-step instructions for using the new Availity application, review our quick reference guide in the **Resources** section of our **payer space**. If you have questions about using Availity, please call **(423) 535-5717, option 2**, or contact your eBusiness Regional Marketing Consultant.

Resources for Your Patients Transitioning Out of Foster Care

We're here to make the transition from foster care to adulthood easier for your patients. Our team works closely with the Department of Children's Services (DCS) to ensure these young adults are connected to community resources and other programs, depending on their health needs.

Teens ages 14-16 will work with the DCS Independent Living division to develop an independent living plan, and starting at 17, a transition plan. Depending on each teen's needs and goals, these plans can help with:

- Life skills
- Education – high school and beyond
- Driver's education and getting a license
- Housing
- Employment
- Medical and mental health care
- Applying for Social Security benefits

Your patients aging out of foster care who stay in Tennessee may be able to keep their TennCare health benefits until they turn 26. They can confirm the status of their health coverage by calling TennCare Connect at **1-855-259-0701**, visiting **tenncareconnect.tn.gov** or contacting their DCS representative.

We can also help connect patients to programs that provide extra support, like Employment and Community First CHOICES for people with intellectual and development disabilities, and community agencies that can assist with housing, transportation, food, utilities and dental care.

If you have questions about the resources available to your patients, please visit **bluecare.bcbst.com**. Providers caring for children in state custody can find helpful information about working with us and DCS by visiting **bluecare.bcbst.com/providers** and selecting **Caring for Children in State Custody and With Other Special Needs**.

Medicaid Reverification and How to Help Members Avoid Gaps in Coverage

On **April 1, 2023**, the Division of TennCare started the reverification process for Tennesseans with BlueCare, TennCare*Select* and CoverKids coverage. This process will continue through early 2024 as TennCare reviews 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 **TennCare Connect**, 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 TennCare Connect or by calling **1-855-259-0701**.
- Open and respond to all mail from TennCare.

You can find more information by visiting TennCare's **Preparing for Renewals** **web page**.

How patients can find alternative coverage

We offer a wide range of affordable Marketplace health plans – and are ready to help individuals and families find the plan that best suits their needs. If a patient needs assistance, they can call us directly at **1-866-886-6545** or shop plans online at **https://message.bcbst.com/shop-plans/**.

BlueCare Plus (HMO D-SNP)SM

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

Annual Wellness Visits

Now is a good time to remind patients about their annual wellness visit. Those who complete a wellness exam are more likely to continue with important tests and screenings throughout the year. During the annual wellness visit, 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. And, you can help your patients with BlueCare Plus Tennessee coverage earn rewards for their healthy living by scheduling a check-up.

If you have questions, call our Provider Service Line at **1-800-299-1407**, Monday through Friday from 8 a.m. to 6 p.m. ET.

Check Prior Authorizations in Availity

You can use Availity to see if your request needs a prior authorization, and to check the status of your authorization request. As a reminder, clinical documentation is required when requesting a review for prior authorization. Including clinical information will help avoid delays in the prior authorization determination. If you have questions, please reach out to your **eBusiness Marketing Consultant**.

In-Home Retinal Eye Exams

Did you know your patients can have a diabetic retinal eye exam completed in the comfort of their home? We work with an in-home vendor to ensure your patients don't miss out on a screening when it's needed. If you have questions on how to help a patient facilitate in-home testing, please call our Provider Service Line at **1-800-299-1407**, Monday through Friday from 8 a.m. to 6 p.m. ET.

Medicare Advantage

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

Outpatient Requests in Availity

We've updated our system to allow additional outpatient requests in Availity using guidelines in the Local Coverage Determination, National Coverage Determination and MCG guidelines for medical necessity reviews. We'll be adding more outpatient codes to allow for automated authorizations. If you have any questions, please contact your **eBusiness Marketing Consultant**.

BlueCare Plus (HMO D-SNP)SM and Medicare Advantage

This information applies to both our BlueAdvantage and BlueCare Plus plans.

Quality Care Rewards (QCR) Application Attestation Reminders

Attestation is available for the Statin Therapy for Patients with Cardiovascular Disease (SPC) and the Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) measures.

SPC measure attestation details

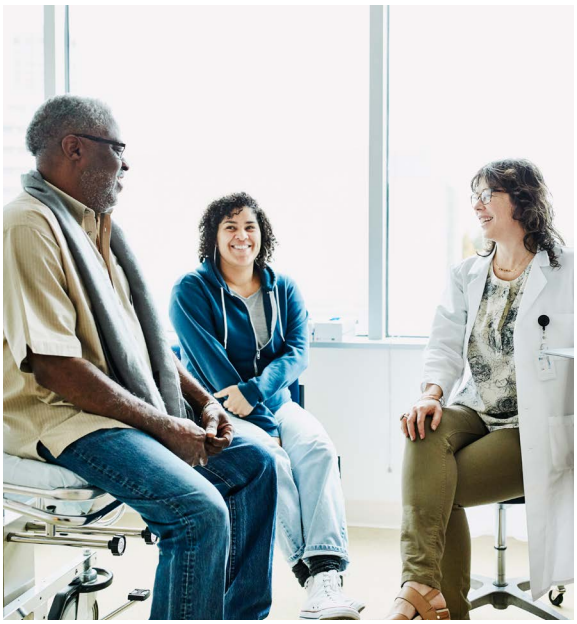
Attestations for patients in the SPC measure are only **allowed for measure exclusions and statins filled through self-pay, the Veteran's Administration (VA) and Patient Assistance Programs (PAPs).** Attestations for statins filled at the pharmacy using the patient's Part D benefit aren't needed as the pharmacy claim data will satisfy the requirement if the medication fill meets all other requirements (minimum dosage of a specific statin filled during the measurement year). Please allow four to six weeks for the claims data to process and close the gap. Attestations for statins filled through self-pay, VA and PAPs require a photocopy of the prescription bottle or pharmacy receipt that includes the full label with patient identification, medication name, dose, route and dispensed date to be submitted with the attestation. Attestations for SPC exclusions require documentation from the medical record to support the exclusion to be submitted with the attestation.

FMC measure attestation details

Attestations for patients in the FMC measure are **only allowed for telephone visits completed on the day of or within the seven days after ER discharge.** Attestations for office visits aren't needed as the claim will satisfy the requirement of the measure if it was completed in the appropriate time frame. Please allow four to six weeks for the claims data to process and close the gap. Attestations for telephone visits require documentation of the telephone visit from the medical record to be submitted.

SPC and FMC measure attestations without proper supporting documentation are subject to removal from the QCR application.

Please contact your Medicare Advantage Provider Quality Outreach Consultant for more information or questions about the SPC and FMC measure attestations.



Medication Reconciliation Post-Discharge Documentation Reminder

The Medication Reconciliation Post-Discharge (MRP) component of the Transitions of Care (TRC) measure can be met through administrative claims filing or by attestation in the Quality Care Rewards (QCR) application. Medication reconciliation can be conducted by a prescribing practitioner, clinical pharmacist or registered nurse within 30 days after discharge. To attest to the MRP component, documentation in the outpatient record must demonstrate the provider was aware of the hospitalization, the date the discharge medications were reconciled with the most recent medication list in the outpatient medical record and the credentials of the provider performing the reconciliation.

Please contact your Medicare Advantage Provider Quality Outreach Consultant for more information or questions about the MRP measure.

Kidney Health Evaluation for Patients with Diabetes (KED) Measure

As of **Jan. 1, 2024**, the Quality+ Partnerships program has added the **Kidney Health Evaluation for Patients with Diabetes (KED)** measure as a single-weighted measure.

The KED measure evaluates the percentage of patients 18-85 years old with diabetes (type 1 or type 2) who received a kidney health evaluation, which is defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year. Patients need to have both an eGFR and a uACR on the same or different dates of service during the measurement year. To satisfy the uACR component, the patient must have either a urine albumin-creatinine ratio test or both a quantitative urine albumin test and a urine creatinine test with service dates four or fewer days apart.

This measure can be closed through administrative claims or by attestation in the Quality Care Rewards (QCR) application in Availity. If you're attesting to this measure in the QCR application, an attestation must be submitted for each test completed.

Please contact your Medicare Advantage Provider Quality Outreach Consultant for more information or questions about the KED measure.

Quality Care Rewards (QCR) Application Attestation and Assessment Deadline for 2023 Program Year

Provider Assessment Forms and measure attestations must be submitted by **Jan. 31, 2024**, to be processed for the 2023 program year. Attestations and assessments completed by a non-clinical user role will show a status of **Pending** and will be in your queues under the **Approval Queue** tile. Be sure to check both queues for pending attestations and assessments needing submission by a clinical-level user role. Remember, pending attestations and assessments not submitted by a clinical-level user role from the queue are automatically deleted after 90 days. Assessments with a date of service over 90 days can't be submitted. Once attestations and assessments have been submitted by a clinical-level user role, their status will be updated to **Submitted**. Assessments will remain in the **Submitted** status with no further processing required. Once submitted attestations are processed, their status will update to **Reconciled**.

Please contact your Medicare Advantage Provider Quality Outreach Consultant for more information or questions about attestations and assessments.

Pharmacy

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

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.

Reminder About Billing for Molecular Diagnostic Tests with Unlisted Codes

When billing for 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 text and the **LAB/MFR TEST ID** number must be submitted for review.

If you have questions, please 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).

Quality Care Rewards

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

Medicare Advantage 2024 Quality Program Measures

As of **Jan. 1, 2024**, the measures included in the 2024 Quality+ Partnerships program are listed below 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)	PDE Files	3
Medication Adherence for Non-Insulin Diabetes Medications (OAD)	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)	PDE Files	1
Transitions of Care (TRC)	HEDIS®	1

Please contact your Medicare Advantage Provider Quality Outreach Consultant for more information or questions about the measures included in the 2024 Quality Program.

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
Seven days/week, 8 a.m. to 9 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 or facility:

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

Update your provider profile on the **CAQH Provider Portal** website

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