BlueAlert ^{SM}

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.

Register for the 2024 All Blue Workshop℠

This year's All Blue Workshop is two short months away and **registration officially opens June 4**. Just click **here** to sign up for the full-day, virtual event, which is set for **Thursday, Aug. 1**. You can also register by visiting the All Blue Workshop **page** on provider.bcbst.com after June 4. Space is limited, so be sure and register soon. For more information, please contact your Provider Network Manager.

Member ID Cards Now on Availity®

Availity Eligibility & Benefits now includes the member ID card for all BlueCross members. Here's how to find your patient's information:

1. Log into **Availity**

2. Click **Patient Registration**, and select **Eligibility & Benefits Inquiry**

From this screen, fill in the provider information and then enter the member's information in Search Options. Select a member from the results and click submit. The member's benefits will display, and you can click the Member Card button to view the front and back of the ID card.

If you have technical issues or general questions, please call **(423) 535-5717, option 2**.

Update Council for Affordable Quality Healthcare (CAQH) With All Credentialing/ Recredentialing Documentation

Please be sure to update CAQH with all information needed to be credentialed or recredentialed with us. This information includes, but isn't limited to, the name and NPI of the supervising physician, name and NPI for the person providing call coverage or covering for the colleague, certificate of insurance (COI) and all certifications needed to process the request.

Beginning **Sept. 1, 2024**, we'll no longer accept documentation via email that can be updated in CAQH. All credentialing or recredentialing updates must be made and attested to in CAQH. As a reminder, it's important to keep CAQH updated with all necessary information to ensure our data is as accurate as possible.

Discharge Summaries in Availity

As a reminder, you can save time by adding discharge summaries directly in Availity. Here's how to add:

1. Go to **Payer Spaces**.

2. Select the **Authorization Submission Review** application.

3. Select **Auth Inquiry/Clinical Update** and open the existing authorization.

4. Go to the Clinical Update section at bottom of page.

5. Add Discharge information.

Please contact your **eBusiness Marketing Consultant** for your Availity questions or training needs.

Manage My Organization Updates in Availity

The upcoming changes in the Manage My Organization (MMO) system will enhance the security and accuracy of provider records. With the new policy, only users assigned the roles of **Administrator** or **Admin Assistant** will have the authorization to add, edit or delete provider records. This update will address the current limitation of non-administrator entries defaulting to third-party/external status and will display the status of providers correctly.

Free Shared Decision-Making Tools in Availity

Shared decision-making (SDM) is a model of two-way communication that involves providers and patients discussing health care options with evidence-based information, the provider's knowledge and the patient's preferences. Please take a moment to access your free and updated SDM tools, or printable handouts, in Availity.

We've updated these aids to offer more options, including decision points related to medical tests, medications, surgery and other treatments/issues, such as:

- **Breast Cancer Risk: Should I Have a BRCA Gene Test?**

- **Aspirin: Should I Take Daily Aspirin to Prevent a Heart Attack or Stroke?**

- **Arthritis: Should I Have Knee Replacement Surgery?**

- **Kidney Failure: When Should I Start Dialysis?**

To use these resources, simply log in to Availity and go to BlueCross **Payer Spaces**. From there, choose the **Resources** tab and click the link to show all resources. Select the SDM tool you want to view, and it will open in a new browser tab for you to review with your patient or print. If you have questions about using the Availity tool, please contact your eBusiness Regional Marketing Consultant.

Updated Health Reimbursement Account (HRA) Information in Availity

The **Eligibility & Benefits** application has been enhanced in Availity to show the individual and family HRA balance including the remaining balance details. If you have additional questions about the member's benefits, you can click the **Coverage Questions** button to get to the **Fast Path** phone number and member transaction ID number.

If you need Availity training, please contact your **eBusiness Marketing Consultant**.

Evaluation and Management CPT® Codes Shouldn't be Applied for Admission through Availity

When submitting prior authorizations for inpatient or observation care, please don't apply CPT® codes such as 99221, 99222 and 99223. The Milliman Care Guidelines (MCG) will display correctly based on the diagnosis code on the authorization. If the member meets the MCG guideline criteria, authorizations may receive immediate approval without these procedure codes. If you use these CPT® codes, the authorization is more likely to be held for review.

Enter Individual NPIs When Requesting Prior Authorizations

When requesting a prior authorization, always enter the Individual NPI into the **Requesting/Servicing** provider field for BlueCard® and BlueCross BlueShield of Tennessee members. If the Group NPI is submitted, the authorization will appear to be out of network, which may delay the authorization.

Updated Lab Testing Policies

Effective **Sept. 1, 2023**, we implemented the Avalon Healthcare Solution Laboratory Procedures Reimbursement Policy. These edits are based on industry standards and are centered on input from a dedicated staff of full-time clinical professionals. All policies have been extensively researched and are reviewed and updated as necessary. You can read more about them below.

Screening for cervical cancer

Some recent policy changes apply to how often providers should screen for cervical cancer. Here's our current policy for these types of screenings:

For women ages 21-29

- Every three years with cytology alone

For women ages 30-65

- Every three years with cytology alone

- Every five years with high-risk human papillomavirus (hrHPV) testing alone or every five years with co-testing

You can find more information by referring to the **Laboratory Testing Code Reimbursement Policies** document under the **Coding Updates** section at **provider.bcbst.com**.

Prior Authorization Letters Now Available in Availity

We're happy to announce you can now view prior authorization letters in Availity. To view:

1. Log in to **Availity**.

2. Click on **Payer Spaces** and select the **BlueCross BlueShield of Tennessee logo**.

3. Select the **Authorization Submission/ Review** application.

4. Go to the **Auth Inquiry/Clinical Update** drop-down arrow then click **BCBST** to search for the existing authorization.

5. Next, choose the **case ID number** to view the authorization details.

6. Look for the letter section in the upper right to **view and print** the authorization letters.

Please contact your **eBusiness Marketing Consultant** for your Availity questions or training needs.

Sign Up to Receive Important Communications by Email

With increases in telehealth visits, changes in office staff and updated office locations, we've noticed more providers are asking to receive important communications by email. You can receive contract-related communications – including fee schedule updates – up to three days faster by switching from mail to email.

If you'd like to switch to email, simply update your **Contact Preferences** through our **Payer Spaces** in **Availity**. There, you can select email instead of mail for five different types of communications. You can add a contact name and email address for contracting, credentialing, network operations, network updates, quality and clinical information and financial updates.

You can update your Contact Preferences by:

1. Logging in to **BlueCross Payer Spaces** in Availity.

2. Selecting the **Contact Preferences & Communication Viewer** tile.

3. Choosing your **Contact Type**.

4. Selecting your **Organization** and **Tax ID**.
   (Tax ID is a newly added feature that lets you select a specific provider based on Tax ID. You can update contact information for all Tax IDs, including the primary Tax ID associated with the corresponding NPI.)

5. Picking a **Provider** from the drop-down list or directly entering the provider's **NPI** and clicking **Submit**.

   Tip: If you don't see your name in the drop-down list, you can add it through the **Manage My Organization** dashboard. For contracting contact, you may have multiple provider names in the left pane, so select the name(s) you want to update.

6. Following 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. When finished, click **Save & Submit**. You can apply the same updates to other contact types by checking **Contact Type** boxes – or the **Select All** box, which automatically checks all contact types you have access to. In some cases, you may find it takes time to receive these messages through your newly specified email, and you may temporarily receive them as you did before.

A **Contact Preference Quick Reference Guide** is available under the **Payer Spaces Resources** tab in Availity. If you have questions, please log in to Availity or contact eBusiness Technical Support at **(423) 535-5717, option 2**.

Save Time with Digital Drug Prior Authorization Requests

Did you know you can avoid on-hold wait times by submitting provider-administered drug prior authorization requests in Availity? You can speed up submission and have access to a dashboard of all your open and completed coverage reviews.

You can find instructions in the **Provider-Administered Drug Prior Authorization Quick Reference Guide** in Availity's **Payer Spaces** under **Resources**. If you need access to Availity, check with your office Availity Administrator. If your office doesn't have access to Availity, you can register your organization at: **availity.com/Essentials-Portal-Registration**.

For help getting started, contact your eBusiness Marketing Consultant for training and education. Please note, self-administered drugs can still be requested through **CoverMyMeds** or **Surescripts**.

Providers New to Our Medicaid Networks Need a Medicaid ID to Enroll

As a reminder, individual practitioners joining a group practice that participates in our BlueCare^{SM} and TennCare*Select* networks need a Medicaid ID from the Division of TennCare before applying with us.

Group practice managers should start the Medicaid ID process immediately after learning a new practitioner is joining their group. You can find more information on the **TennCare site**.

In addition, individual practitioners joining a new group must be eligible to participate in all networks the group is contracted for. They'll also need a valid and current CAQH profile, which can be managed through the **CAQH Provider Data Portal**.

For more information, providers should reach out to their Provider Network Manager.

Commercial

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

Changes to Genetic Testing Program Prior Authorization

Beginning **Aug. 1, 2024**, the following codes will be added to the Genetic Testing prior authorization list in the EviCore Genetic Testing Program.

0020M, 0452U, 0453U, 0454U, 0456U, 0460U, 0461U, 0464U, 0465U, 0466U, 0467U, 0469U, 0470U, 0473U, 0474U, 0475U

Beginning **Aug. 1, 2024**, the following codes will be removed from the Genetic Testing prior auth list in the EviCore Genetic Testing Program.

0204U, 0353U

Changes to Radiation Oncology Program Prior Authorization

Beginning **July 1, 2024**, the following codes will be added to the Radiation Oncology prior authorization list in the EviCore Radiation Oncology Therapy Program.

32553, 49411, 49412, 55876

Behavioral Health Acute Inpatient Prior Authorizations

As a reminder, inpatient behavior health prior authorizations can be submitted online through Availity. If the member meets the clinical criteria for an authorization request, you may receive an approval. If you need to check the details or update an existing authorization, that's easily handled through Availity.

If your practice needs Availity training and education, contact your **eBusiness Marketing Consultant**.

BlueCare Tennessee

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

Backdate PCP Assignment Changes Up to Three Business Days

You can change a patient's PCP assignment in Availity within three days of the date of the visit. If you're working over the weekend, for example, you can hold the change information until the beginning of the following week. If you submit the change within three business days of the visit, we'll accept it.

If you get an error when trying to submit a PCP change in Availity, please print or download the page with the error. Then, email the error information to **Fax_PCP@bcbst.com** or fax it to **1-888-261-9025** so we can investigate the issue.

For help using the Availity PCP Change Maintenance application, please contact your eBusiness Regional Marketing Consultant.

Join Us for the June 2024 EPSDT Virtual Coding Workshop

Please plan to attend the first Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coding workshop of 2024, scheduled for **June 20** from 11:30 a.m. to 1 p.m. CT (12:30 p.m. to 2 p.m. ET). During the virtual session, we'll provide updates, and you'll hear from the Tennessee Chapter of the American Academy of Pediatrics. Topics we'll cover include:

- An overview of EPSDT
- Submitting appropriate diagnosis codes and billing procedures
- Submitting claims with appropriate codes and modifiers
- EPSDT documentation requirements
- BlueCare Tennessee Resources

Registration is required. Please **click here** and fill out the registration form to save your spot. We hope you can attend and look forward to connecting with you.

Note: The information in this article doesn't apply to CoverKids.

Reminder for Vaccines Filed with Modifier SL

Remember to always bill the SL modifier on vaccine procedure codes for all state-supplied vaccines. This modifier shouldn't be billed on administration codes.

Guidelines for Submitting Electronic Secondary Claims

It's important to use correct insurance indicators and policy numbers to avoid delayed payments and denials.

Use insurance indicator 16, Health Maintenance Organization (HMO) Medicare Risk, when submitting electronic claims for services secondary to traditional Medicare (Parts A and B), Dual Special Needs plans and Medicare Advantage plans to avoid delays in payment. Claims submitted with incorrect insurance indicators will be denied.

Additionally, please ensure that policy numbers are entered correctly for all secondary claims. Secondary claims submitted with incorrect or invalid policy numbers will also be denied.

Promote Access to Timely Prenatal Care

Prenatal care is an essential part of improving the health of pregnant members and babies in our state. By serving in our BlueCare, TennCare*Select* and CoverKids networks, providers agree to make regular and urgent prenatal appointments within these timelines:

Members in their first trimester of pregnancy

- **Regular appointments:** Within three weeks of the member's request

- **Urgent appointments:** Less than 48 hours from the date of the member's request

Members in their second and third trimesters of pregnancy

- The first prenatal appointment should occur within 15 days of Medicaid eligibility.

Seeing patients within these timeframes can also help improve performance on Healthcare Effectiveness Data and Information Set (HEDIS®) quality measures.

HEDIS Measures Related to Prenatal and Postpartum Care

The quality measure related to timely care during and after pregnancy has two components:

- **The Timeliness of Prenatal Care** component assesses the percentage of deliveries that received a prenatal care visit within the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.

- **The Postpartum Care** component assesses the percentage of deliveries that had a postpartum visit on or between seven and 84 days after delivery.

For more information about these measures, please see our **Quality Care Measures provider guide**. To learn more about our BlueCare Tennessee and CoverKids Maternity Care Program and how we support our members and network providers, click **here**.

Psychotropic Medication Monitoring in Children and Young Adults

Psychotropic medications affect how the brain works and cause changes in mood, awareness, thoughts and feelings. They're typically prescribed to children and teens to manage conditions, such as attention-deficit/hyperactivity disorder, anxiety, depression and mood disorders. Recently, increases in psychotropic medication use has led to concerns that some young patients are being misdiagnosed with psychiatric disorders and treated with inappropriate medications.

Our goal is to help promote the safe and appropriate use of psychotropic medications in children with behavioral health disorders by sharing resources and best practices. If you have questions about psychotropic medication use, please call **1-800-367-3403** to speak with a board-certified psychiatrist or consult with an expert about treatment.

Strategies for Successful Care

Consider these tips when treating young patients with psychotropic medications:

- **Develop a plan for short- and long-term monitoring.** Consider the type of medication, risk of side effects, the patient's need for ongoing psychosocial support and other factors when developing this plan. Keep in mind that children taking an antipsychotic medication need annual metabolic testing, including blood glucose and cholesterol testing.

- **Educate families, and work with the Department of Children's Services (DCS) as needed.** After performing an evaluation and proposing a treatment plan, educate families about the diagnosis, medication, expected benefits, potential side effects and alternatives to medication to ensure they can make an informed decision. **Note:** If your patient is in foster care, you must get consent from the child's regional nurse consultant before starting medication. Once treatment begins, DCS monitors the prescribing and drug utilization patterns of children in foster care to ensure these patients get safe, appropriate treatment. This may include working with DCS regional nurse consultants, the DCS chief medical officer or other personnel.

We're Here to Help

Short-term and long-term medication monitoring is medically necessary, and there are special considerations for children in DCS custody. We're here to help and work with the Tennessee Chapter of the American Academy of Pediatrics to offer free training to help providers diagnose and manage patients with behavioral health needs. For more information about this training, visit **tnaap.org/programs/behip/behip-overview/**.

Facilitating the Transition from Pediatric to Adult Care

Young adulthood is a time of change, including finding a new health care provider. Our members are eligible for EPSDT exams until their 21st birthday, but each provider office may have different age limits for when they stop seeing young adults.

This transition can be difficult for patients. Pediatric providers play an integral role in transitioning patients to an adult primary care provider. Consider these tips when working with young adults who are getting ready to age out of pediatric care:

- Each EPSDT exam should include anticipatory guidance/health education. This is a great time to have conversations about transitioning to a new provider and the importance of continuing regular checkups and preventive care, including dental and eye exams, into adulthood.

- Begin discussing the transition of care early. For example, if your office transitions patients to adult care at age 18, start the discussion no later than the patient's 17th birthday. This will give them at least one year to find a new provider.

- Share a printed or electronic health summary with young adult patients that includes medications, results from the most recent health visit (including labs and vitals), any diagnoses and vaccines.

- Make sure you get the name and contact information of the patient's new provider so you can send over their medical records. If your patients have complex medical or behavioral health needs, consider a "warm hand-off" visit with your patient, their family members and their new care team.

- Encourage patients to begin taking ownership of their health in early adolescence. This includes scheduling appointments for immunizations and checkups, and managing their medical history, allergies and medications. Practicing these tasks will make it easier for young adults to manage their care independently when the time comes.

Promoting Well-Child Care

Sometimes, patients go several years between well-child visits. This is especially true for teens and young adults. Consider using the patient reminder tools, such as letters, text messages and reports, in your electronic medical record to make scheduling easier. Also, schedule the next well-child exam before patients leave your office so a plan of care is in place. Finally, some practices have found success offering extended or alternate office hours (such as evening or weekend hours). If you're interested in expanding your office hours, consider asking families what times are most convenient for them to visit your office.

Behavioral Health Acute Inpatient Prior Authorizations

As a reminder, inpatient behavioral health prior authorizations can be submitted online through Availity. If the member meets the clinical criteria for an authorization request, you may receive an approval. If you need to check the details or update an existing authorization, that's easily handled through Availity.

If your practice needs Availity training and education, contact your **eBusiness Marketing Consultant**.

BlueCare Plus Tennessee

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

Use Availity to Change Members' Primary Care Provider

The **BlueCare Primary Care Provider (PCP) Change Maintenance** application is now available in Availity. We're phasing out the existing PCP Change Request Form and will no longer accept these requests by fax or email.

Beginning **June 1, 2024**, providers will need to use the BlueCare PCP Change Maintenance application to change the PCP for a member with **BlueCare Plus** 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.

When you use the application, changes are made in real time. 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.

2024 Special Needs Plan Model of Care (MOC) Training is Now Available

Providers participating in BlueCare Plus Tennessee special needs plans are contractually required to complete our Model of Care Training after initial contracting, then every year afterwards. This training promotes quality of care and cost effectiveness through coordinated care for our members with complex, chronic or catastrophic health care needs. You can access the online self-study training and attestation at **bcbst.com/model-of-care-training**.

Medicare Advantage

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

Forms for Provider Appeals

To ensure we're processing your provider appeals quickly, please complete and submit the appropriate form. If you're appealing a denial for **clinical medical necessity** you'll need to complete the **Provider Appeal Form (Claim Reconsideration Appeal)**. If you have questions or disagree about a payment you'll need to complete the **Provider Reconsideration Form**.

These forms can be found on **provider.bcbst.com** under **Medicare Advantage**, then under **Authorizations & Appeals**.

Medicare Advantage and Dual Special Needs Plan

This information applies to our BlueAdvantage (PPO)ˢᴹ and BlueCare Plus Tennessee plans unless specifically identified below.

Update to Refraction Code

Effective Jan. 1, 2024, claims with procedure code 92015 will deny with provider liability. Refractions are considered part of the medical vision exam and aren't separately reimbursed. If you have questions, please refer to your **Provider Administration Manual**.

Encourage Your Patients to Get a Bone Mineral Density Screening

Bone mineral density (BMD) tests, which screen for osteoporosis and osteopenia, are especially important for patients who've had a fracture. To meet the requirements of the **Osteoporosis Management in Women Who Had a Fracture (OMW)** HEDIS® measure, women ages 67-85 who've had a fracture should have a BMD test within six months of the fracture.

Sometimes, patients refuse a BMD test after a fracture because they don't think they need it or understand getting a test after a fracture can still add clinical value. Consider these tips to encourage BMD testing and help make sure your patients get the care they need:

- Talk about the benefits of screening after a fracture, which include confirming the diagnosis of osteoporosis, predicting the chance of future fractures and determining the rate of bone loss.

- Discuss available options for testing (X-rays, dual-energy X-ray absorptiometry [DEXA or DXA] or a CT scan to determine bone density of the hip or spine).

- Review common risk factors so patients can manage their risk of low bone mass. In addition to advancing age, these include smoking, excessive alcohol use, certain medical conditions (including rheumatoid arthritis, type 1 diabetes, liver disease, kidney disease, hyperthyroidism or hyperparathyroidism), a family history of hip fracture, and using steroids long-term.

- Let patients know that treatment is available, and starting treatment early helps minimize bone loss and prevent future fractures.

For more information about the OMW measure see our **Quality Program Information Guide**.

Opportunity for Frailty Exclusions

The Centers for Medicare & Medicaid Services (CMS) allows patients to be excluded from certain quality measures when they have specific advanced illness and/or frailty diagnoses. Exclusions are made because the services recommended in the HEDIS® definition may not benefit older adults with advanced illness, which limits their ability to receive certain treatments.

Frailty conditions and their accompanying ICD-10 codes are often not captured during routine office visits. Annual wellness exams offer a yearly opportunity to address gaps in care as well as possible exclusions. Coding eligible frailty conditions at least twice on different dates of service during the current year makes the patient eligible for exclusions related to frailty with some quality measures.

Common frailty conditions in the senior population include:

- History of falling (Z91.81)
- Weakness (R53.1)
- Muscle weakness (M62.81)
- Other malaise (R53.81)
- Other fatigue (R53.83)
- Difficulty in walking (R26.2)

If you have questions about exclusions or codes for advanced illness and frailty, refer to our **Guide to Advanced Illness and Frailty Exclusions**.

Pharmacy

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

Change in Commercial Preferred Drug List

Beginning **July 1, 2024**, we're removing Levemir® vial, Levemir® FlexPen®, and Levemir® FlexTouch® from our Preferred Drug List for Commercial lines of business. We'll send letters to any members impacted by this change. Please consider prescribing a covered alternative for your patients who are currently prescribed these medications.

You can view the full list of covered drugs and preferred alternatives in the **2024 Preferred Formulary Guide**. If you have questions, please contact your Provider Network Manager.

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** 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 PlusSM	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**.