of Tennessee

JANUARY 2026

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.

Keep Your Information Current

Please make sure your information is accurate in your CAQH account. Keeping this information current helps make sure that all communications from us are delivered successfully.

INSIDE THIS ISSUE

Member ID Card Changes Coming for All Blue Plans by 2028

The Blue Cross Blue Shield Association is requiring all Blue plans to update Member ID cards by 2028. Updates will include removing the suitcase icon, which identifies members with the BlueCard benefit.

Please check Availity® to confirm a member's benefits or eligibility.

We're still in the planning phase, but providers may start seeing updated cards from members with other Blue plans or BlueCard benefits soon.

Continue to check the BlueAlert for updates.

Change of Ownership Reminder

If you're acquiring or being acquired by a provider facility or group, you must give us at least 60 days advance notice of change of ownership (CHOW). You also need to submit a CHOW notification using the **Provider Change of Ownership Notification Form**. Once the transaction has closed, send us a copy of the executed bill of sale or purchase document (minus the purchase price) within five business days of closing. If you don't provide the required notice or documents, your payments could be impacted.

For more details about CHOW requirements, please consult your BlueCross provider agreement or our PAM. You can also find additional information in the Frequently Asked Questions document **here**.

Submit All Same-Day Services on One Claim

To help ensure accurate processing and timely payment, please remember:

- **All services performed for the same patient on the same day at the same place of service and by the same provider must be submitted on a single claim.** This includes professional and institutional charges. We may deny the second or subsequent claims if multiple claims are submitted for the same date of service.
- **We only accept split billing if we've requested it to reflect covered charges allocated for approved and denied dates of service.** Split bills that we haven't requested are subject to denial or recoupment.
- **Providers must bill all services rendered on the claim.** For example, you must include an ER revenue code with the related CPT® code if the patient received care or was admitted through the ER. If you find a coding error on a claim, please refile the entire claim. We won't accept partial corrections or split submissions. **Note:** We may recoup payment if certain codes/services are excluded from a claim.
- **Providers should submit professional charges on the CMS-UB04/ANSI-837 Professional Transaction and institutional charges on the CMS-UB04/ANSI-837 Institutional Transaction.** Claims data should be complete and filed for all covered and non-covered services.

For more billing guidance, please see the **Provider Administration Manual** for your line of business.

Stay Informed by Submitting Prior Authorizations in Availity

Submitting prior authorizations through the **Prior Authorization Tool** in Availity gives you more options and can make the decision process faster than submitting them directly to Cohere.

When you submit a prior authorization in Availity:

- The system will send your prior authorization to the appropriate place/vendor.
- Availity verifies the Member ID is active.
- You can verify the status of authorizations.
- You can easily locate authorization letters.
- You can quickly update existing authorizations.

If you have questions about submitting a prior authorization in Availity, please call **(423) 535-5717**, **option 2**, or contact your **eBusiness Regional Marketing Consultant**.

A Faster Way to Receive Important Communications From Us

You can receive contract-related communications – including fee schedule updates – up to three days faster by switching from mail to email. By selecting email and adding a contact name and email address, you can also request email for credentialing, network operations, network updates, quality and clinical information, and financial updates.

You can update your contact preferences through our **Payer Spaces** in Availity. Simply select email instead of mail for all types of communication and add a contact name and email address for each one.

Follow these steps in Availity:

1. Log in to **BlueCross Payer Spaces**.
2. Select the **Contact Preferences & Communication Viewer** tile.
3. Choose your **Contact Type**.
4. Select 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. Pick a provider from the drop-down list or by directly entering the provider's **NPI** and click **Submit**.
6. Follow the remaining cues and check the email **Opt In** box. Make 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.

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

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**.

Coming Soon: New Inquiry, Reconsiderations and Appeals Tool in Availity

We're excited to announce our new online inquiry, reconsiderations and appeals tool in Availity is launching soon. Providers currently submit by phone, fax, mail and email. This new tool streamlines that process.

We encourage providers to submit inquiries, reconsiderations and appeals in Availity as soon as the tool is live. During the interim, we've disabled the "Message this Payer" feature as we move to the new process.

Please note that all in-state providers will eventually be required to submit inquiries, reconsiderations and appeals through Availity, and we'll no longer accept these submissions by fax, mail or email.

For more information, please contact your **eBusiness Regional Marketing Consultant**.

Commercial

This information applies to Blue Network P℠, Blue Network S℠, Blue Network L℠ and Blue Network E℠ unless specifically identified below.

Understanding the Behavioral Health (BH) Comprehensive Network

Medical providers are typically contracted for specific Commercial networks—such as Networks P, S, L and E. Depending on the region, a provider may be part of one or several of these networks.

BH providers are contracted into the BH Comprehensive Network, which automatically includes all Commercial networks (P, S, L and E). They're considered in-network for any member with a Commercial plan.

Multi-Specialty Group Practices

Some health care group practices include both medical and BH providers. While the BH provider may be in-network due to the BH Comprehensive Network, the medical provider in the same practice might not be in-network for the member's specific Commercial plan.

Examples where a multi-specialty health care group practice is contracted for Commercial Networks P, S, L and/or E along with the BH Comprehensive Network:

Scenario 1:

- The member's policy is supported by Network S.
- The health care group practice is contracted in Network P and the BH Comprehensive Network. However, the provider isn't contracted for Network S.
- In this scenario, the member would have in-network benefits with the BH provider, because the BH Comprehensive Network covers all networks.
- The medical providers in the group would be out-of-network for the member because they only participate in Network P.

Scenario 2:

- The member's policy is supported by Network S.
- The health care group practice is contracted in Network P and S and the BH Comprehensive Network.
- In this scenario, the member would have in-network benefits with the BH provider **and** medical provider, because the BH Comprehensive Network covers all networks, and the medical provider is in the member's network.

Updates with this clarification are being made to the Provider Quick Reference Guide.

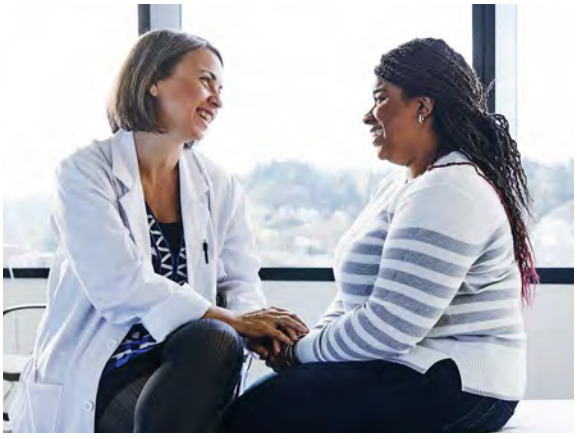
Future Updates: See the Latest and What Changes Are on the Way

Please review the table below to find the latest information from us and what changes are on the way. If you have questions, please contact your Provider Network Manager. If you're unsure who that is, go to **My BlueCross Contact**. For questions about medical policy updates, please send an email to **medical_policy@bcbst.com**.

Update Type	Availability	Where to Find It
Coding Updates	60 days before the effective date	Go to the **Coverage & Claims** page on **provider.bcbst.com**. Updates are located under **Coding Updates** in the **Coding Information** section.
Lab Testing Policies	60 days before the effective date	Go to the **Documents & Forms** page on **provider.bcbst.com**.
Upcoming Prior Authorization Changes	60 days before the effective date	Go to the **Documents & Forms** page on **provider.bcbst.com**. Updates are located under **Upcoming Prior Authorization** Changes in the **News & Updates** section.
Pharmacy Updates	Updated as needed	Download a summary of select upcoming drug prior authorization criteria changes **here**.
Medical Policy Updates	60 days before the effective date	Go to the **Manuals, Policies & Guidelines** page on **provider.bcbst.com**. Updates are located under **Coverage**.

BlueCare Tennessee

This information applies to BlueCare℠, TennCareSelect and CoverKids plans unless specifically identified below.



Tennessee Department of Health (TDH) Legislative Updates for OB/GYN Providers

New state legislation took effect on **July 1, 2025**, expanding mandatory prenatal screenings for syphilis and hepatitis. It also requires all hospitals and birth centers to share information about post-birth warning signs with their patients before discharge. You can review TDH's memo **here** for more information about these new guidelines.

To continue getting updates about these changes, complete the **TDH OB/GYN Network Survey**.

New Health Care Benefits for Incarcerated TennCare Members

Effective **Jan. 1, 2026**, eligible TennCare members get limited benefits when preparing for release and in the transition period after release from state prisons, local jails, juvenile detention centers and youth correctional facilities.

Eligibility

Individuals must meet these requirements to qualify:

- Be TennCare-eligible
- Under age 21 or up to age 26 if formerly in foster care
- Post-adjudication
- Eligible for release or transitioning after release from incarceration

Covered Benefits

Benefits include a screening and diagnostic visit (physical, dental and behavioral health) and targeted case management 30 days before release and full benefits including targeted case management, dental and pharmacy for 30 days after release.

Participating Providers

To provide well-visits and targeted case management to eligible incarcerated members, providers must:

- Have a National Provider Identifier (NPI) and Tennessee Medicaid ID.
- Complete the Provider Enrollment Steps and satisfy BlueCare Tennessee's credentialing and participation requirements.
- Enroll in the TennCareSelect provider network.
- Sign a participating provider agreement.
- Comply with any requirements set by the jail or prison where care is provided.
- Submit claims after providing services.

Please email **Contracts_Reqs_GM@bcbst.com** or call **1-800-924-7141** if you have questions or are interested in providing these services.

Consider Performing Well-Child and Sick Visits on the Same Day

Sometimes, kids and teens go several years between checkups, and an office visit for an illness, shots or prescription refill is the only chance you have to perform a well-child exam. That's why TennCare Kids' screening guidelines allow providers to get reimbursement for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits performed at the same time as other services.

When patients visit your office for care, consider checking your patient roster in the Availity **Quality Care Rewards** application to see if they're up to date on preventive care. Then, perform well-child services during the appointment as appropriate.

Please note: Patients may schedule an appointment for a sports physical, but stand-alone sports physicals aren't covered services for BlueCare Tennessee members. Instead, convert a sports physical into a complete well-care visit, if appropriate, to meet the requirements for both and be reimbursed for a covered service. For more information, please see our **EPSDT Provider Tool Kit**.

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

Enhancing Partnerships Between Providers, Foster Parents and Youth in Foster Care

Providers play an important role in supporting foster families and meeting children's medical and developmental needs. Below, we've included helpful tips to consider when working with foster parents and youth.

- **Help foster parents address health issues.** In addition to performing developmentally appropriate health screenings, providers can help foster parents recognize and manage emotional, physical and behavioral health concerns. Consider talking with foster parents about warning signs that children are having a difficult time processing their emotions or experiencing signs of past and present trauma, including:
  - Changes in eating and sleep habits
  - Separation anxiety
  - Mood fluctuations
  - Nightmares
  - Headaches
  - Stomach pain
  - Reacting strongly to situations or withdrawing
- **Connect foster families to community resources, like support groups, local organizations and early child intervention programs.** Keep in mind that grandparents and other family members caring for children in kinship care may need extra support, including financial assistance.
- **Model positive language about adoption, foster care and kinship care.** The American Academy of Pediatrics recommends providers help parents determine how and when to have developmentally appropriate conversations about the child's placement status, their birth parents or events in the past that may be difficult to discuss but help build trust.
- **Incorporate elements of trauma-informed care (TIC) into your approach to caring for children and teens in state custody.** Listen to children, teens and caregivers in active, nonjudgmental ways to help facilitate discussions about trauma. Additionally, when performing an exam or asking questions, consider explaining why you need to do so.

For more information about ways you can help support foster families and youth, please see these resources:

- **Pediatrics** – **Pediatrician Guidance in Supporting Families of Children Who Are Adopted, Fostered, or in Kinship Care | Pediatrics | American Academy of Pediatrics (aap.org)**
- **American Academy of Pediatrics** – **Trauma parenting insert (aap.org)**
- **American Academy of Pediatrics** – **Helping Foster and Adoptive Families Cope with Trauma**

BlueCare Plus Tennessee and Medicare Advantage

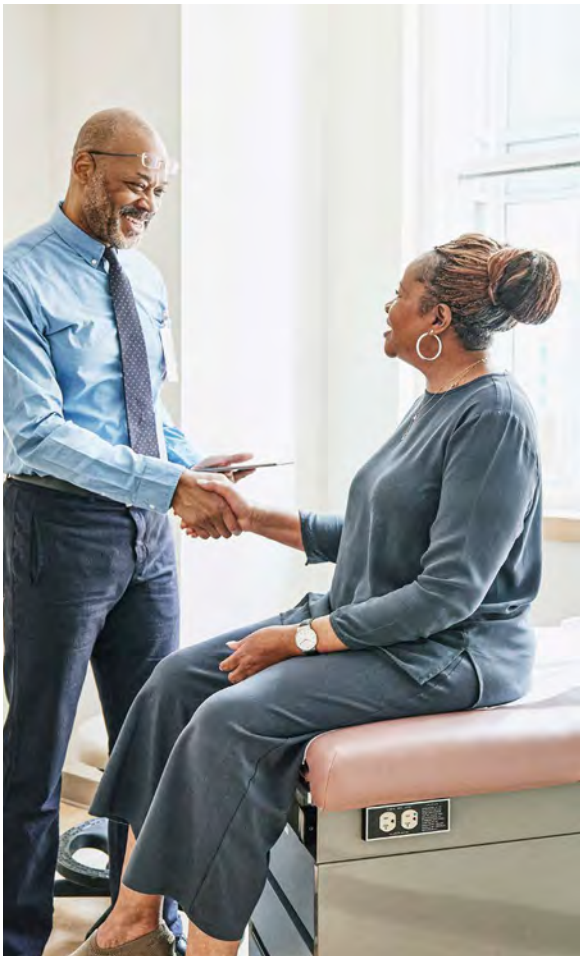
This information applies to our Medicare Advantage and BlueCare Plus Tennessee plans unless specifically identified below.

New Care Management Vendors

This year, we'll work with several new vendors to strengthen care management and improve patient outcomes. Here's a list of who we're working with and what we plan to accomplish:

- **Thyme Care** – Deliver personalized, clinically coordinated care navigation for patients diagnosed with (or suspected to have) cancer. Their oncology-trained providers, nurses and community resource specialists can function as an extension of your practice, offering between-visit support, streamlining clinical workflows and enhancing the patient experience.
- **HarmonyCares** – Provide comprehensive, home-based health care services for patients with Medicare coverage and those managing complex medical conditions.
- **Spiras Health** – Help your patients with chronic conditions improve their quality of life.

Check future newsletters for more information coming soon.



Medicare Advantage 2026 Quality Program Measures

Effective **Jan. 1, 2026**, the following changes apply to the quality measures included in the Medicare Advantage Quality+ Partnerships program:

- The **Medication Adherence** measures weight is reduced from 3 to 1.
- The measures listed below are excluded from the program for the 2026 performance year.*
  - **Eye Exam for Patients with Diabetes (EED)**
  - **Osteoporosis Management in Women Who Had a Fracture (OMW)**
  - **Statin Therapy for Patients with Cardiovascular Disease (SPC)**
  - **Polypharmacy – Multiple Anticholinergic Medications (Poly-ACH)**
- The **Member Experiences** measures are:
  - **Consumer Assessment of Healthcare Providers and Systems (CAHPS): Care Coordination**
  - **Health Outcomes Survey (HOS): Improving or Maintaining Physical Health**

*While these measures are excluded from the program, they're still measures we focus on as a plan.

The 2026 program year measures are listed below in order of measure weight:

Measure	Source	Weight
Controlling Blood Pressure (CBP)	HEDIS®	3
Glycemic Status Assessment for Patients with Diabetes (GSD)	HEDIS®	3
Plan All-Cause Readmissions (PCR)	HEDIS®	3
Medication Adherence for Cholestoral (Statin)	Prescription Drug Event (PDE) Files	1
Medication Adherence for Hypertension (RAS Antagonist)	Prescription Drug Event (PDE) Files	1
Medication Adherence for Non-Insulin Diabetes Meds (OAD)	Prescription Drug Event (PDE) Files	1
Breast Cancer Screening (BCS)	HEDIS®	1
Colorectal Cancer Screening (COL)	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
Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) Files	1
Trasitions of Care (TRC)	HEDIS®	1
Member Experience—CAHPS (BCBST CMS Score/Healthmine Mock Survery)	CMS Member Survey/ BCBST Mock Survey	2
Care Coordination		
Member Experience—HOS (BCBST CMS Score/Healthmine Mock Survey)	CMS Member Survey/ BCBST Mock Survey	2
Improving or Maintaining Physical Health The following 2 measures are included for C-SNP patients and are also part of the D-SNP program.		
Care for Older Adults (COA)—Functional Status Assessment	HEDIS®	1
Care for Older Adults (COA)—Medication Review	HEDIS®	1

Please contact your Medicare Advantage Provider Quality Outreach Consultant for more information or questions about the measures in the 2026 quality program.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Upcoming Retrospective Audit of SNF and IRF Authorizations

We're planning a retrospective audit of Skilled Nursing Facility (SNF) and Inpatient Rehabilitation Facility (IRF) authorizations for our Medicare Advantage products. The review will kick off in early 2026.

We'll look at submitted claims to make sure authorizations were issued correctly and followed CMS guidelines and our internal policies.

To help things go smoothly, please make sure your documentation is complete and easy to access. If you have any questions, please reach out to your Provider Network Manager.

New Post-Acute Care Partnership with tango and WellSky®

Soon, we'll begin working with **tango** and **WellSky** to manage skilled home health and post-acute facility services for Medicare and Medicaid dual-eligible special needs plans.

tango

Skilled home health services – nursing, therapy, aid and social work

WellSky

Post-acute facility services – skilled nursing facilities, inpatient rehab facilities and long-term acute care hospitals

We'll work with tango and WellSky to help manage:

- Referral coordination
- Prior authorization and continued stay reviews
- Transition of care support
- Provider and member experience oversight

If you have questions, please contact one of the options below:

- Home Health – **contractmanagement@tangocare.com**
- Post-acute – **PACSupport@WellSky.com**
- Phone – **1-888-224-1409**
- Web – **providerresourcecenter.com/bcbstn**

BlueCare Plus Tennessee

This information applies to our Medicare and Medicaid dual-eligible special needs plans unless specifically identified below.

Changes to the Healthy Food Benefit

This year, members with certain long-term conditions may be able to get a healthy food benefit. It's a Special Supplemental Benefit for the Chronically Ill (SSBCI). If they qualify, they can use their monthly flex card allowance to pay for healthy food. However, all members can use their allowance on over-the-counter (OTC) items and transportation.

Not all members will qualify for the healthy food benefit. Members can check for eligibility and allowance information in the **MyTotal Benefits** app. They'll use the same login info for both **bcptncard.com** and the app.

If you have patients who aren't getting this benefit but think they should, please complete the attestation form during their next visit. You can fax the completed form to **1-855-876-1461**.

Upcoming Changes for BlueCare Plus Tennessee Dual Eligible Members

Starting **Jan. 1, 2026**, we've made important updates to improve care for members with both Medicare and Medicaid. These changes help make getting care easier and more coordinated for members. They also simplify the claims process for providers.

What changed?

Members who have BlueCare Plus Tennessee and BlueCare Medicaid have been moved to one of the BlueCare Plus Tennessee Fully Integrated Dual Eligible (FIDE) plans. This change only affects people who are dually eligible and currently enrolled in BlueCare Medicaid.

What does this mean for members?

These members now have their Medicare and Medicaid services managed under one plan. Members get one ID card for both Medicare and Medicaid services, and the card shows the BlueCare Plus Tennessee plan name and policy number.

What does this mean for providers?

Providers should send all claims (Medicare and Medicaid) to BlueCare Plus Tennessee. You don't need to submit a separate claim to BlueCare Medicaid. This helps make billing simpler and reduces delays.

Prior authorization requests for services should also go to BlueCare Plus Tennessee, using the member's BlueCare Plus Tennessee ID number (usually starts with ZEUY or ZEU9).

What are self-service options for providers?

To support these changes, providers should continue to use Availity to:

- Check member eligibility.
- View claim status.
- Submit prior authorization requests or check the status.

Note: BlueCare Plus Tennessee offers three plans. This update applies **only** to members with **BlueCare Plus (HMO D-SNP)℠ and BlueCare Plus Choice (HMO D-SNP)℠** plans who are also enrolled in BlueCare Medicaid.

Complete the 2026 Special Needs Plan Model of Care (MOC) Training

Providers participating in BlueCare Plus Tennessee special needs plans are contractually required to complete our MOC training after initial contracting, then every year afterward. 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 by **clicking here**.

Quality Corner

This information applies to all lines of business unless specifically identified below.

Strengthen Preventive Care by Encouraging Annual Wellness Visits

By prioritizing annual wellness visits, providers can empower patients to take charge of their health. These visits are more than routine check-ins; they're strategic opportunities to build trust, detect issues early and reinforce healthy behaviors across all age groups.

Annual wellness visits serve as a cornerstone of preventive care. They allow providers to:

- Identify emerging health risks before symptoms appear.
- Update immunizations and screenings based on age and risk factors.
- Discuss lifestyle choices that influence long-term health.
- Establish continuity of care, especially for patients managing chronic conditions.

For pediatric patients, these visits track developmental milestones and ensure timely vaccinations. For adults, they offer a chance to screen for silent conditions like hypertension or diabetes. For older adults, they support cognitive assessments, fall prevention and advance care planning.

Wellness Measures Impacting HEDIS® Score Outcomes

WellCare Visits (W30)

Well-Child Visits in the First 15 Months apply to patients who are up to 15 months old during the measurement period: Six or more well-child visits meet the measure performance. Well-Child Visits for Age 15 Months–30 Months is for patients who turned 16-30 months old during the measurement period: Two or more well-child visits meet the measure performance.

Child and Adolescent Well-Care Visits (WCV)

Patients 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement period.

Adults' Access to Preventive/Ambulatory Health Services (APP)

Patients 20 years and older who had an outpatient or preventive care visit during the measurement period.

Annual Wellness Visit (AWV)

Wellness Visit (AWV) once every 12 months for Medicare beneficiaries.

Tips to help your patients schedule their wellness exams every year.

- Check your patient list for overdue wellness visits.
- Launch a reminder campaign via email, text or patient portal.
- Schedule next year's wellness appointment as part of the wellness visit this year. Wellness visits aren't required to be 365 days apart, just once in the calendar year.
- Ask your patients if they're receiving care from other providers to improve care coordination.
- Address and close care gaps by reviewing open gaps and capturing data which closes preventive gaps in care during wellness visits.

If you have questions, contact your Provider Quality Representative or your Provider Network Manager.

Pharmacy

This information applies to our Medicare plans unless specifically identified below.

Restrictions for Opioids

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

These restrictions were implemented in 2019 and will continue through 2026:

- Pharmacies will receive a safety edit when members are prescribed more than 90 morphine milligram equivalents (MME*) by two or more prescribers.
- Opioid-naïve members are limited to seven days for their initial fill.
- Members prescribed more than 200 MME by two or more prescribers will automatically reject, and the pharmacist can't override the rejection unless the member has an exempt diagnosis (cancer, sickle cell, etc.). If the member still requires more than 200 MME, the member, prescriber or representative can request a prior authorization.
- Concurrent use of long-acting opioids is restricted.
- Concurrent use of opioids and benzodiazepines is restricted.

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

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

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

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

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

BlueAdvantage

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

BlueCare Plus Tennessee

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

2026 Drug List Changes

Each year, we review our drug lists and make changes based on a drug's safety, effectiveness and affordability. Although many of these changes happen at the beginning of the year, they may occur at any time because of market changes. These can include, but aren't limited to:

- Release of new drugs to the market after FDA approval
- Removal of drugs from the market by the FDA
- Release of new generic drugs to the market

Please visit the following links on the **Pharmacy Resources & Forms** page:

- To see the 2026 Preferred Formulary and 2026 Essential Formulary changes, click **here**.
- To see the 2026 BlueAdvantage Formulary and 2026 BlueAdvantage Extra (PPO)SM formulary, click **here**.
- To see the 2026 BlueCare Plus Tennessee Formulary, click **here**.

Biosimilar Drugs

Effective **Jan. 1, 2026**, we removed Humira (adalimumab) from our Essential and Essential Plus Formularies. We're covering these biosimilars instead:

- Simlandi
- Adalimumab-adaz
- Hadlima

We also removed Stelara from the Preferred, Essential and Essential Plus Formularies. We're covering these biosimilars instead:

- Selarsdi
- Imuldosa
- Yesintek

We mailed letters to affected members to let them know. We also sent letters to providers with a list of impacted members. We loaded new prior authorizations for the biosimilars to make sure members have a smooth transition with no extra prior authorization required.

If you have any questions, please reach out to the provider support team. We appreciate the care you give our members.

Refer to the TennCare Pharmacy Benefit Manager for Important Updates

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

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
Monday–Friday, 8 a.m. to 6 p.m. (ET)	
BlueCare Plus℠	1-800-299-1407
Seven days/week, 8 a.m. to 6 p.m. (ET)	
***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**.