BlueCross BlueShield of Tennessee, Inc. (BCBST)  
(Applies to all lines of business unless stated otherwise)

CLINICAL

Medical policy updates/changes

The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the “Upcoming Medical Policies” link.

Effective Feb. 12, 2012

- Auricular Electrostimulation
- Chelation Therapy
- Lymphedema Devices
- Surgical Treatment of Femoroacetabular Impingement

Note: These effective dates also apply to BlueCare /TennCare Select pending State approval.

Modified Utilization Management Guideline changes

BlueCross BlueShield of Tennessee’s website has been updated to reflect upcoming modifications to select Modified Utilization Management Guidelines. The Modified Utilization Management Guidelines can be viewed on the Utilization Management Web page at http://www.bcbst.com/providers/UM_Guidelines/Upcoming_Changes/Upcoming_Changes.htm

Effective Feb. 22, 2012

The following as relates to Inpatient and Surgical Care:

- Renal Transplant

BlueCross BlueShield of Tennessee will begin using Milliman Care Guidelines® 15th edition for Wound Care. The following Modified Utilization Management Guideline related to Wound Care will be archived:

- Wound Care

Note: Effective dates also apply to BlueCare and TennCareSelect pending state approval.

New drugs added to commercial specialty pharmacy listing

Effective Jan. 1, 2012, the following drugs have been added to our Specialty Pharmacy drug list. Those requiring prior authorization are identified by (PA).

Provider-administered via medical benefit:
- Alimta (PA)
- Erwinaze (PA)
- Eylea (PA)
- Nexplanon

Self-administered via pharmacy benefit:
- Caprelsa (PA)
- Ferriprox
- Jakafi (PA)
- Targretin (PA)

To obtain prior authorization for provider-administered specialty drugs call BlueCross at 1-800-924-7141.

For prior authorization of self-administered specialty drugs call Caremark at 1-877-916-2271.

ADMINISTRATIVE

Reminder: Prior authorization not required for anesthesia

Anesthesiology claims filed for outpatient surgeries will not be denied if no authorization is on file. Prior authorization is the responsibility of the outpatient facility and surgeon.

Reminder: Acknowledgement of financial responsibility

If a BlueCross BlueShield of Tennessee network participating provider renders a service that is investigational or does not meet Medically Necessary and Appropriate criteria, the provider must obtain a written statement from the member prior to the service(s) being rendered. The written statement will acknowledge the member understands he/she will be responsible for the cost of the service(s) and any related service(s). This can also be used for member requests for non-emergency cosmetic or elective services specifically excluded under the member’s health benefit plan.

To assist providers in this process, BlueCross has developed the Acknowledgement of Financial Responsibility for the Cost of Services form. This form can be found in the provider administration manuals, on BlueSource, our quarterly provider information CD and on the company website, www.bcbst.com. BlueCross strongly encourages providers to use this form as it meets contractual obligations of our network providers.

2012 HEDIS® medical record review project set to begin

BlueCross BlueShield of Tennessee and Volunteer State Health Plan, Inc. will begin its annual Healthcare Effectiveness Data and Information Set (HEDIS®) project in February 2012. This is required to meet National Committee for Quality Assurance (NCQA) accreditation, as well as Bureau of TennCare and Centers for Medicare and Medicaid reporting requirements.

The Bureau of TennCare has expanded the measures that must be reported using medical record review this year. We will be seeking records for 17 different measures that focus on prevention and screening, diabetes care, cardiovascular care, access and availability and utilization.
Getting the best impression

The first person your patients usually see is the Medical Receptionist. The journal, Social Science and Medicine, recently published a study on their work. The study found receptionists are not just the “gatekeepers” or “person behind the desk.” Their responsibilities often extend way beyond their administrative duties. They are a vital part of patient care.

Medical receptionists deal directly with everyone coming into the office from patients to pharmaceutical representatives, mail men, lab couriers, etc. In addition to their administrative function, they may confirm prescriptions with an angry patient, congratulate a new mother, console a patient whose spouse just died or help a mentally ill patient make an appointment. A significant portion of their work involves managing the emotions and care of patients and families.

Medical receptionists are a key part of the relationship between patients and doctors and patients’ feelings about the receptionist may be reflected in their opinions of their doctor.

P4 Pathway Oncology Program update

P4 Pathway codes have been updated on the Provider page of the company website at http://www.bcbst.com/providers. Please refer to the P4 code list for current program codes and the generic incentive list effective Jan. 1, 2012. The website also provides a link to the P4 website with additional information about the P4 Pathway Oncology Program.

Reminder: Prior authorization fax requests no longer accepted on weekends and holidays

Fax transmission may be submitted to the Utilization Management Department Monday through Thursday, 24-hours-a-day and on Friday, or the day before a BlueCross BlueShield of Tennessee holiday, until 4 p.m. (ET).

- Commercial Fax 1-866-558-0789
- Cover Tennessee Fax 1-800-851-2491

Reminder: Requesting urgent concurrent reviews for inpatient stays and emergent admissions

Submit online requests for commercial lines of business, including Cover Tennessee, for urgent concurrent reviews and emergent admissions through BlueAccess 24-hours-a-day, 7-days-a-week. For immediate attention outside regular business hours, (Monday through Thursday 9 a.m. to 6 p.m. ET and 9 a.m. to 4 p.m. ET on Fridays and holidays) requests must be submitted by phone.

Requests will be accepted within 24 hours or the next business day after admission by calling the prior authorization number listed on the member’s ID card or the Utilization Management Department at 1-800-924-7141.

Musculoskeletal management*

As previously communicated, select procedures now require prior authorization. Musculoskeletal is one of the areas in focus to help patients to receive higher quality care and improve clinical outcomes for patients suffering from musculoskeletal pain.

Effective March 1, 2012, BlueCross BlueShield of Tennessee will begin requiring prior authorization for the following musculoskeletal procedures for both commercial fully-insured and MedAdvantage plans.

- Pain Management
- Spinal Surgery
- Joint Surgery (Hip, Knee & Shoulder)
- Physical Medicine (MedAdvantage only)

Please note medical records may be required for the initial authorization review. Requests for authorization can be submitted by calling 1-800-388-8978, via www.bcbst.com web authorization or by fax to 1-800-520-8045. Musculoskeletal codes requiring prior authorization may be subject to change.

BlueCross BlueShield of Tennessee, Inc. (BCBST)
(Appplies to all lines of business unless stated otherwise)

ADMINISTRATIVE (Cont'd)

2012 HEDIS® medical record review project set to begin (cont’d)

A BlueCross BlueShield of Tennessee representative will be contacting your office in the near future to request documentation or schedule an onsite review of medical records for data abstraction. All information should be received prior to May 18, 2012, to meet strict reporting timeframes for this project.

If you use a copy service, please notify them of the need to respond promptly to requests for records. BlueCross providers are required to submit copies of requested medical records without charge.

Note that BlueCross BlueShield of Tennessee and providers can continue to share information related to a member’s protected health information (PHI) without a member’s authorization when the information is needed for health care treatment or payment activities.

The privacy element of the Health Insurance Portability and Accountability Act of 1996, (HIPAA) works to protect members’ PHI but also allows use by providers and insurers in the course of normal business when related to treatment, payment or health care operations (TPO).

Reminder: Dialysis center provider billing requirements

The composite rate, revenue codes: 0821, 0831, 0841, or 0851 should only be billed to BlueCross BlueShield of Tennessee when an actual dialysis treatment visit has been performed within the clinic. BlueCross allows the lesser of total covered charges or a percentage of all-inclusive composite rates negotiated in the contract. Except where specifically noted in the contract, the composite rate includes all services, drugs and supplies associated with dialysis, dialysis training or a combination of dialysis and training. In the event an inappropriate payment has been made, BlueCross reserves the right to recover the reimbursement.

*These changes will be included in the appropriate 1Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

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BlueCross BlueShield of Tennessee, Inc. (BCBST)
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ADMINISTRATIVE (Cont’d)
Reminder: Reimbursement of overpayment

If there is a payment from an auto insurance or Workers’ Compensation that results in an overpayment, it is the responsibility of the provider to reimburse BlueCross BlueShield of Tennessee the overpaid amount. Providers should clearly state “auto paid claim” or “workers’ comp paid claim” on the reimbursement to indicate the reason for the payment.

If a provider receives more than he/she should have when benefits are provided by a third party carrier, the provider will be expected to repay any overpayment to the appropriate insurer.

Reminder: Importance of taxonomy codes

Some providers are contracted with BlueCross BlueShield of Tennessee under multiple specialty types, but have only one National Provider Identifier (NPI). A taxonomy code helps BlueCross identify the correct BlueCross Provider Identifier Number (PIN) for claims payment.

To avoid delayed claims payment, or payments being issued to the wrong PIN, submit claims using the appropriate taxonomy code.

BlueCare/TennCareSelect

CLINICAL

Appropriate antibiotic treatment

It is the time of year when your office will be filled with patients sniffling and coughing. Is it a cold or an infection? Studies have shown most patients expect to leave their doctor’s office with a prescription, especially for antibiotics. If the patient has had the symptoms less than three days, you may want to provide educational materials and share your treatment rules to explain the risks of antibiotics outweigh the benefits. The Centers for Disease Control and Prevention (CDC) estimates that more than 100 million antibiotic prescriptions are written each year in the ambulatory care setting. With so many prescriptions written each year, inappropriate antibiotic use will promote resistance. In addition to antibiotics prescribed for upper respiratory tract infections with viral etiologies, broad-spectrum antibiotics are used too often when a narrow-spectrum antibiotic would have been just as effective. Volunteer State Health Plan continually plans new initiatives to specifically promote Best Practices. It is hoped that these interventions will improve rates, as has been the case for other areas of preventive care, such as annual well-care visits and immunizations.

The following Healthcare Effectiveness Data and Information Set (HEDIS®) measures of focus have been identified as priorities to improve the quality and health of our population. Our goal is to work with providers and members to increase the use of appropriate antibiotic treatment in adults with acute bronchitis (AAB) and children with upper respiratory infections (URI). It is our hope to promote an increase in understanding for our members with member mailings, newsletter articles and the development of provider posters. You may receive an onsite visit from a clinical team to discuss how we can work together toward this goal.

Sources:


HEDIS appropriate treatment for children with URI = the percentage of children 3 months-18 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.

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*Goal represents a meaningful improvement over the prior year as stated in the National Committee for Quality Assurance’s (NCQA) minimum Effect Size Change Methodology

**National HMO benchmark from the 90th percentile of NCQA’s Medicaid HEDIS 2011 Quality Compass

Reminder - LDL-C & HbA1c initiative: Diabetes gaps in care

Volunteer State Health Plan, Inc. (VSHP) has partnered with LabCorp to use Lab-in-an-Envelope, an alternative approach to closing gaps in comprehensive diabetes care.

Lab-in-an-Envelope kits, with easy-to-follow instructions, will be mailed to non-compliant diabetic members who have gaps in LDL-C Screening and HbA1c Testing upon health plan receipt of physician order. This is a dry spot testing kit that contains all the necessary collection supplies and may be mailed to the member’s home. The dry spot is then mailed back in a pre-addressed, pre-paid envelope. The lab results will be faxed to your office to help you in managing your patient’s care.

Some providers may receive an onsite visit from our clinical team and receive an educational packet that includes member details that you might find useful in treating your BlueCare and TennCareSelect patients who suffer from diabetes. Our goal is to work with providers to increase HbA1c testing rates, LDL-C screening rates, reduce diabetes gaps in care, and improve diabetes care.

Please support this initiative by authorizing VSHP to send Lab-in-an-Envelope kits to
Reminder - LDL-C & HbA1c initiative: Diabetes gaps in care (Cont’d)

your patients with diabetes that show gaps in care for HbA1c-and/or LDL-C. Providers may send individual or batch authorizations for identified members. If you have any questions, please call VSHP’s Disease Management department at 1-888-416-3025, Monday through Friday, 9 a.m. to 6 p.m. (ET). The MD order Lab-In-An-Envelope Authorization fax form may be found on our website at <http://www.bcbst.com/providers/forms/Lab-in-an_Envelope_MD_Fax.pdf> or you may request a form from disease management.

Changes to diabetic supplies order process*

To be consistent with TennCare’s Pharmacy Benefit Management (PBM) billing guidelines, effective Jan. 1, 2012, providers will begin ordering supplies listed below through SXC Health Solutions, Inc.

Members currently receiving their supplies through VSHP will need to transition to SXC by March 1, 2012. After March 1, 2012, diabetic supplies will no longer be available through VSHP.

During this transition, for new members or members that have not previously received supplies through VSHP, providers should feel free to use SXC to avoid having members make another change on March 1, 2012.

- Alcohol Pads
- Blood Glucose Meters
- Blood Glucose Test Strips
- Glucose Control Solution
- Insulins
- Insulin Syringes
- Ketone Testing Strips (i.e. Ketostix®)
- Lancets
- Pen Needles- Syringe Needles

To order diabetic supplies, complete the Prior Authorization Form for Diabetic Supplies located on the SXC Health Solutions website at <https://tmm.providerportal.sxc.com/rxclaim/TC%20PA%20Request%20Form%20(Diabetic%20Supplies).pdf>.

Fax the completed form to SXC at 1-866-434-5523.

Contact Provider Service for BlueCare at 1-800-468-9736 or TennCareSelect at 1-800-276-1978 if you have any questions or need assistance in transitioning existing members to SXC.

ADMINISTRATIVE

OB delivery admission information*

Effective Feb. 1, 2012, network facilities will no longer be required to notify BlueCare/TennCareSelect of maternity delivery admissions. These services are not subject to prior authorization/notification requirements, but may be subject to retrospective review based on Medical Policy. All services provided by out-of-network providers require prior authorization. All NICU admissions require authorization regardless of network status.

Reminder: Monthly federal exclusion list screening

BlueCare and TennCareSelect providers have a monthly obligation to screen all employees and contractors against the U.S. Department of Health and Human Services’, Office of Inspector General’s List of Excluded Individuals/Entities (located at www.oig.hhs.gov) and the General Services Administration’s List of Parties Excluded from Federal Programs (located at www.epls.gov).

If an employee or contractor is found to be on the list, Medicaid providers must immediately report any exclusion information discovered to Volunteer State Health Plan and remove such employee or contractor from responsibility for, or involvement with a provider’s operations related to federal health care programs. Appropriate actions must be taken to ensure the responsibilities of such employee or contractor have not or will not adversely affect the quality of care rendered to any VSHP member of any federal health care program.

Note: Additional information may be found in the Volunteer State Health Plan Provider Administration Manual in the Highlights of Provider Agreement section.

Reminder: Important claims information

BlueCare/TennCareSelect claims must meet the following requirements or they will be rejected in their entirety and returned to the provider.

Type of bill (TOB) 089x

- Dates of service on a claim cannot span calendar months.
- Dates of service billed on line items must be within the claim header ‘From & To’ dates.
- The header “From” date must equal the earliest detail “From” date and the header “To” date must equal the latest detail date.

TOB 066x

- Dates of service on a claim cannot span calendar months.
- For room and board codes 0183, 0185, 0189, 0191, 0192, dates of service billed on line items must be within the claim header “From” and “To” dates.
- The header “From” date must equal the earliest detail “From” date and the header “To” date must equal the latest detail date.

Clarification: SelectCommunity included in TennCareSelect network

Recently, there have been questions about whether or not TennCareSelect providers are part of the SelectCommunity network and vice versa. All participating TennCareSelect providers are eligible to provide services to SelectCommunity members.

*These changes will be included in the appropriate 1Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.
Clarification: SelectCommunity included in TennCare Select network (Cont’d)

The SelectCommunity Network is composed of Primary Care Providers (PCPs) who have agreed to fulfill special roles and responsibilities associated with the management and care of SelectCommunity members. In exchange for fulfillment of these roles and responsibilities, an enhanced care management fee is paid for each SelectCommunity member who is assigned to their practice. SelectCommunity PCPs utilize the TennCare Select Network for specialty, facility and ancillary care.

If you are a specialty, facility or ancillary care provider in the TennCare Select Network, you are considered in network for SelectCommunity members. If you receive a call from a member asking if you accept SelectCommunity, the answer is, “Yes.”

Please contact TennCare Select Provider Service† if you have any additional questions.

SelectCommunity expansion

Effective Oct. 1, 2011, the Bureau of TennCare’s program for persons with intellectual and/or developmental disabilities (I/DD) called SelectCommunity expanded in the West Grand Region. SelectCommunity will expand to the East Grand Region during the first quarter of 2012, and to the Middle Grand Region later in 2012.

Individuals covered by the State MR (Main) Waiver and Self-Determination Waiver programs are eligible to enroll into SelectCommunity’s Integrated Health Services Delivery model by opting in. An “opt in letter” will be mailed to eligible individuals by the Bureau of TennCare, with a designated time frame for individuals to respond.

SelectCommunity members are assigned a Nurse Care Manager (NCM) who will serve as the member’s and provider’s primary point of contact for physical and behavioral health needs.

An Electronic Visit Verification (EVV) system will be used to monitor the initiation and daily provision of home health/private duty services, in accordance with the member’s individualized plan of care, and allow immediate action to resolve any service gaps.

All participating TennCareSelect providers are already contracted and eligible to provide services to SelectCommunity members. In addition, a special SelectCommunity Primary Care Network, similar to the Best Practice Network, has been developed. If you are a PCP, and would like to participate in the SelectCommunity Primary Care Network, or if you are not in the TennCareSelect network, but would like to be part of this holistic approach to health care for persons with intellectual and/or developmental disabilities, please call the Blue Cross BlueShield of Tennessee Provider Service line, 1-800-924-7141, and say “Network Contracting” when prompted.

Reminder: Utilization Management Reviews

To perform timely reviews of your faxed requests and avoid submission of duplicate requests, please be advised that VSHP has up to 14 days to complete non-urgent requests. Please allow up to 14 days to receive a response. If at that point you have not received a response, please feel free to contact us at:

BlueCare 1-888-423-0131
TennCareSelect 1-800-711-4104

Reminder: Non-discrimination compliance training

Non-discrimination compliance training may be found on the company website at <http://www.bcbst.com/providers/bluecare-tenncareselect/index.shtml>. The training includes information about Title VI, and requirements for providing translation services for VSHP members. It is a self-guided training so you may view the information at your leisure.

Reminder: VSHP home health agency requirements

As a reminder, home health agencies providing services to VSHP members should strictly adhere to the coding requirements as mandated by the Bureau of TennCare when billing for services. Failure to comply with the billing guidelines will delay payment for services and could subject agencies to recovery of payments.

Additionally, home health agencies caring for VSHP members are required to notify VSHP immediately of missed visits or shifts. Agencies should always have someone on call after normal business hours to notify VSHP so backup care can be arranged. Please call 800-262-2872 and notify VSHP as soon as you become aware of a potential missed visit or shift so we can help ensure our members receive the care they need. Family members should not be considered an appropriate backup for authorized home health care.

BlueCard® Administrative

Quick tips for a smooth out-of-area claims experience

At BlueCross BlueShield of Tennessee we strive to process claims quickly and accurately. Did you know you can make a difference in how quickly claims are processed? You can!

Following these helpful tips will improve your claim experience:

- Include the member’s complete identification number when you submit the claim. This includes the three-character alpha prefix.
- Ask members for their current member ID card and regularly obtain new photocopies of it (front and back). Having the current card enables you to submit claims with the appropriate member information (including alpha prefix) and avoid unnecessary claims payment delays.

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**BlueCard® Administrative (Cont’d)**

Quick tips for a smooth out-of-area claims experience (Cont’d)

- Check eligibility and benefits electronically at [www.bcbs.com](http://www.bcbs.com) or by calling 1-800-676-BLUE (2583). Be sure to provide the member’s alpha prefix.
- Verify the member’s cost sharing amount before processing payment. Please do not process full payment upfront.
- Indicate on the claim any payment you collected from the patient. In cases where there is more than one payer and a Blue Cross and/or Blue Shield Plan is a primary payer, submit Other Party Liability (OPL) information with the Blue Cross and/or Blue Shield claim.
- Do not send duplicate claims. Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claims payment process and creates confusion for the member.
- Check claim status by submitting an electronic HIPAA 276 transaction (claim status request) to BlueCross BlueShield of Tennessee or by contacting us at 1-800-705-0391.
- If you have any questions about claims filing for Blue members, refer to BlueCross BlueShield of Tennessee Provider Administration Manual or:
  - Talk to your Network Manager
  - Visit us online at: [http://www.bcbs.com/providers/bluecard/](http://www.bcbs.com/providers/bluecard/)
  - Contact us at 1-800-705-0391

**Cover Tennessee**

**CLINICAL**

Performing CoverKids developmental screenings

The State of Tennessee’s CoverKids plan provides comprehensive health coverage for children 18 years of age and under.

Emphasis is placed on preventive care and services most needed by children, including vaccinations, well-child visits, healthy babies program, and developmental screenings.

Providers performing developmental/behavioral screenings for CoverKids children should:

- use a standardized screening tool with interpretation and report;
- indicate in child’s medical record a developmental screening was performed;
- document in child’s medical record screening date, tool utilized and results; and
- file charges on a CMS-1500 claim form utilizing CPT® code 96110.

For more information on the CoverKids plan, visit the State of Tennessee website at [http://www.covertn.gov/web/coverkids_benefits.html](http://www.covertn.gov/web/coverkids_benefits.html).

**Reminder: Disclosure form requirement**

If you are a provider that participates in BlueNetwork S, one of the programs you service is CoverKids. Because the CoverKids program is funded in part by federal dollars, regulations require BlueCross BlueShield of Tennessee to maintain disclosure information on all its CoverKids providers.

BlueNetwork S providers not participating in the BlueCare/TennCareSelect network with no disclosure form on file will soon receive a letter regarding this requirement. Failure to provide a completed disclosure form may lead to sanctions and exclusion from federal health care programs, including CoverKids.

The disclosure form will soon be available in the provider section of the company website, [www.bcbs.com](http://www.bcbs.com).

**BlueAdvantage® Administrative**

**BlueAdvantage out-of-area claims**

For quick tips on a smooth out-of-area Blue Advantage claims please see our BlueCard section of the newsletter. Additionally, check the Provider page on our website at [www.bcbs.com/providers/news/](http://www.bcbs.com/providers/news/) for new information on other Blue plans whose groups have joined our network.

*These changes will be included in the appropriate 1Q 2012 provider administration manual update. Until then, please use this communication to update your provider administration manual.

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**Provider Service lines**

Featuring “Touchtone” or “Voice Activated” Responses

Note: If you have moved, acquired an additional location, or made other changes to your practice, choose the “touchtone” option or just say “Network Contracts or Credentialing” when prompted, to easily update your information.

**Commercial Lines**

1-800-924-7141 (includes CoverTN; CoverKids & AccessTN)

Operation Hours

Monday–Friday, 8 a.m. to 5:15 p.m. (ET)

Medical Management Hours

Monday–Friday, 9 a.m. to 6 p.m. (ET)

**BlueCare**

1-800-468-9736

**TennCareSelect**

1-800-276-1978

**CHOICES**

1-800-747-8955

**SelectCommunity**

1-888-747-8955

**BlueAdvantage**

1-800-841-7434

**BlueCard**

Benefits & Eligibility 1-800-676-2583

All other inquiries 1-800-705-0391

Monday – Friday, 8 a.m. to 5:15 p.m. (ET)

**BlueChoice**

1-800-841-7434

Monday – Friday, 8 a.m. to 5 p.m. (ET)

**eBusiness Technical Support**

Phone: Select Option 2 at 423-535-5717
e-mail: ecom_techsupport@bcbs.com

Monday – Friday, 8 a.m. to 6:30 p.m. (ET)