

BlueAlertSM



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.



Don't Forget to Register for the 2025 All Blue WorkshopSM

Registration for this year's All Blue Workshop is officially open. Sign up [here](#) for the full-day virtual event, which is set for **Thursday, Aug. 14**. You can also register by visiting the All Blue Workshop page on provider.bcbst.com. Space is limited, so be sure to register soon. For more information, please contact your Provider Network Manager.

INSIDE THIS ISSUE

BlueCross BlueShield of Tennessee, Inc.

- [Don't Forget to Register for the 2025 All Blue WorkshopSM](#)
- [Billing for Waste and Administration of No-Waste Drugs](#)
- [Report Supporting Diagnosis Codes](#)
- [Check Member Benefits and Eligibility in Availity as Blues Plans Update ID Cards](#)
- [Coming Soon: New Reconsiderations and Appeals Tool in Availity](#)
- [More](#)

Commercial

- [New Commercial Prior Authorization Submission Process](#)
- [Billing for Commercial Claims](#)
- [Billing Guidelines for Hospice Services](#)
- [Out-of-State \(BlueCard\) Authorizations](#)
- [Upcoming Prior Authorization Changes](#)

BlueCare Tennessee

- [Process Reminders for SelectKids Members: Financial Responsibility and Obtaining Informed Consent](#)
- [HIV Long-Acting Injectable](#)
- [Vision Screenings and Summer Eye Health Tips](#)
- [Join Us for the August 2025 EPSDT Virtual Coding Workshop](#)
- [Help Prepare Your Patients for the New School Year](#)
- [More](#)

BlueCare Plus Tennessee

- [Reminder: Complete the 2025 Special Needs Plan Model of Care \(MOC\) Training](#)

BlueCare Plus Tennessee and Medicare Advantage

- [Authorization Needed for Radiopharmaceuticals](#)

Medicare Advantage

- [Complete 2025 Provider Assessment Forms \(PAFs\)](#)

Quality Care Initiatives

- [Closing the Gap in Care: Follow-Up After Hospitalization for Mental Illness \(FUH\)](#)
- [Promoting Well-Child Care: A Foundation for Lifelong Health](#)

Pharmacy

- [Step Therapy for Additional Medicare Part B Drugs](#)
- [Reminder for BlueCare Plus Tennessee Part B Drug Claims](#)
- [Removing Xhance[®] From Our Preferred Drug List](#)
- [Nuedexta[®] Prior Authorization Requirement](#)
- [Refer to the TennCare Pharmacy Benefit Manager for Important Updates](#)

Tips for Coding Professionals

- [Coding Updates: See the Latest and What Changes Are on the Way](#)

Billing for Waste and Administration of No-Waste Drugs

Our Commercial, Medicare Advantage and BlueCare Tennessee Provider Administration Manuals (PAMs) recommend reporting all codes, including modifiers, in accordance with the governing coding organization. See General Billing and Reimbursement Guidelines applicable to “medication wastage.”

The Centers for Medicare & Medicaid Services (CMS) published HCPCS modifiers for providers to accurately report drug administration and waste units.

- **JW:** Drug amount discarded/not administered to any patient
- **JZ:** Zero drug amount discarded/not administered to any patient

Please use the modifier JW for drug units that were discarded. Providers are responsible for using the most economical packaging of medication for the required dosage with the least amount of medication waste necessary or following the manufacturer’s directions. Waste shouldn’t be billed for medications available in multi-dose vials and isn’t reimbursable.

CMS requires the JZ modifier on all claims for single-dose containers with no discarded amounts. Billing guidelines with examples are provided in these sources:

- **CR 9603-JW Modifier: Drug amount discarded/ not administered to any patient**
- **Internet Only Manual (IOM) 100-4-Claims Processing Manual; Chapter 17-Drugs and Biologicals; Sections 40-40.1**
- **Discarded Drugs and Biologicals - JW Modifier and JZ Modifier Policy Frequently Asked Questions ([cms.gov](https://www.cms.gov))**



What to report

To report claims with drug waste, submit two separate claim lines. One line should include the HCPCS code for the administered drug with no modifier, number of units and price calculated for the administered units only. A second line should report the HCPCS code for the administered drug, with modifier JW to indicate the amount wasted, number of units wasted and the price calculated for the wasted units only. The total units for the two lines shouldn’t exceed the units contained in the most economical single-dose vial.

To report claims that have no waste, only submit one claim line. This line should contain the HCPCS code for the drug administered, with modifier JZ to indicate there was no waste, the appropriate units of the drug administered and the price for the administered units.

We follow the billing guidelines for accurately reporting drug dosages, both administered and wasted. Medical record documentation should be clear to support all billed units. The National Drug Code for the single-dose vial requiring waste should be reported on the claim form. Please refer to the General Billing and Reimbursement Guidelines section of the PAMs for instructions on following government coding guidelines and the fourth quarter PAMs for this updated guidance. Claims will be subject to audit to ensure compliance with these guidelines.

Report Supporting Diagnosis Codes

ICD 10-CM codes are used to report diseases, injuries, impairments, manifestations, and causes of injury, disease, impairment, or other health problems. These codes should be reported in accordance with the Department of Health and Human Services guidelines (e.g., ICD Manual).

Please refer to the **General Billing and Reimbursement Guidelines** in your Provider Administration Manual for more information on accurate code set reporting.

It's important to accurately report the appropriate diagnosis for patient encounters, services, procedures and medications on the claim form. This also applies to services, procedures and medications requiring prior authorization. Even though the supporting clinical information is provided when a prior authorization is requested, the supporting diagnosis must be reported on the claim form just as with any other services, procedures or medications that don't require a prior authorization. Claims that don't have a supporting diagnosis reported will be subject to review.

Check Member Benefits and Eligibility in Availity as Blues Plans Update ID Cards

The Blue Cross Blue Shield Association is requiring all Blues plans to update Member ID cards by 2028. We don't have a timeline for our updates yet – but you may start seeing them from other plans soon.

We recommend using Availity® to check for the most accurate member benefits and eligibility information. As we have more information, we'll share it in future BlueAlerts.

Coming Soon: New Reconsiderations and Appeals Tool in Availity

We're excited to announce our new online reconsiderations and appeals tool will launch later this year. The tool will be available in Availity. Today, providers submit reconsiderations and appeals by phone, fax, mail and email. This new tool will streamline that process.

Want to be an early adopter? Let us know by contacting your **eBusiness Regional Marketing Consultant**.

Find Your Authorizations Faster

You can save time and avoid phone calls by quickly checking an authorization status in Availity. Here's how:

1. Log in to **Availity**.
2. Click on Payer Spaces and choose the **BlueCross logo**.
3. Choose the **Authorization Submission/ Review** application.
4. Go to the **Auth Inquiry/Clinical** Update drop-down arrow, then choose BCBST.
5. Choose the **case ID number** to see the latest status.

We're no longer faxing authorization status letters, but you can view and print them here.* After choosing the case ID number, look for the letter section in the upper right to view and print the authorization letters.

*This doesn't apply to Medicare Advantage.

If you have questions, please call **(423) 535-5717, option 2**, or contact your **eBusiness Regional Marketing Consultant**.

Upcoming Provider Administration Manuals Delayed

To meet operational needs, we're delaying the release of the PAMs for the third quarter (July, August and September) for all lines of business. We'll publish the third quarter PAMs on **July 15, 2025**. Providers in our Commercial networks can view their Commercial Preview PAM for the third quarter [here](#).

We appreciate your patience.

Taxonomy Code Reminder

As a reminder, professional claims need a taxonomy code (unique 10-character code that designates your classification and specialization) to be submitted for billing and rendering providers. The **National Plan and Provider Enumeration System (NPPES)** directory shouldn't be the single source of determining the correct taxonomy.

It's important that both the billing and rendering provider taxonomy codes match how you're credentialed and contracted with us. For example, if you have a pharmacy, specialty pharmacy or Durable Medical Equipment (DME) provider contract, you'll need to file with the specific taxonomy indicated for each contracted service. If you don't submit the appropriate taxonomy codes, your claims may be rejected, denied or result in reduced reimbursement.

Please be sure to file the two-digit qualifier with taxonomy.

Change of Ownership Reminder

Anyone acquiring a provider facility or group 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](#).

Commercial

This information applies to Blue Network PSM, Blue Network SSM, Blue Network LSM and Blue Network ESM unless stated otherwise.

New Commercial Prior Authorization Submission Process

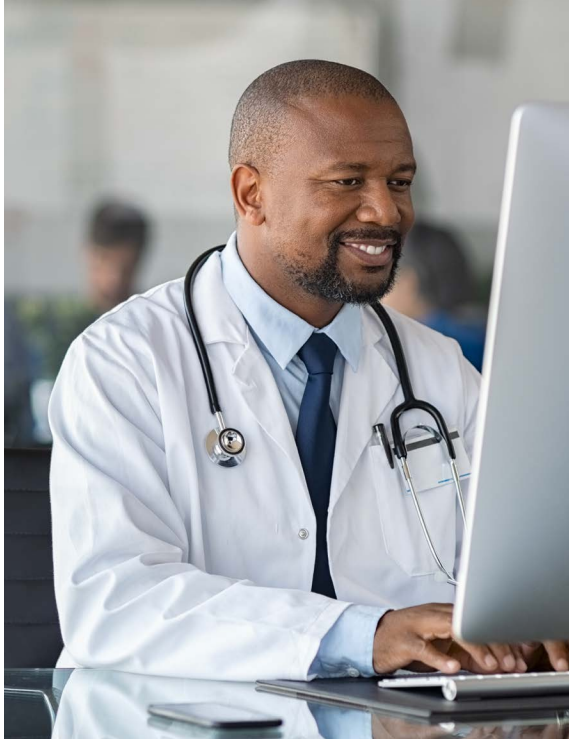
Beginning in September, we'll be using Cohere Health technology to manage most prior authorizations for our Commercial lines of business. For your convenience, you'll continue to submit requests directly to us through Availity.

To learn more about this update, join one of our webinars hosted by eBusiness.

Choose from one of the following August 2025 dates/times:

- Wednesday, Aug. 20 at 10 a.m. ET – [webinar link](#)
- Tuesday, Aug. 26 at 2 p.m. ET – [webinar link](#)
- Thursday, Aug. 28 at 11 a.m. ET – [webinar link](#)

If you have questions about using Availity, please call **(423) 535-5717**, option 2, or contact your **eBusiness Regional Marketing Consultant**. You can find additional training about the Cohere process on Availity.



Billing for Commercial Claims

To help us pay you accurately and process your claims in a timely manner, remember these tips:

Primary diagnosis codes – According to the International Classification of Disease (ICD), certain diagnosis codes can only be billed in the first listed or primary diagnosis code field. There's an identifier in some ICD 10-CM guidelines for these codes. We'll edit the claim line if a primary-only diagnosis code is billed in a position other than first listed or primary.

Professional and technical component indicators – When both the professional and technical components for radiology, lab or other diagnostic procedures are performed, it's appropriate to bill the service as a global procedure (i.e., without a 26 or TC modifier appended to the CPT® or HCPCS code). Improper billing could result in claim denial and delayed payment.

Note: This article only applies to Commercial, Commercial Host and FEP plans.

Billing Guidelines for Hospice Services

If you've experienced any problems submitting claims for hospice services, you can use the following information to help make sure the process goes smoothly:

- Bill using an institutional claim form.
- Bill a separate line item for each date of service.
- Match the total days billed on the inpatient care with the from/through dates on the statement.
- Use Type of Bill (TOB) 081X or 082X in Form Locator 4 if the inpatient and outpatient services are on separate claims.
- Make sure the TOB determines the Place of Service (POS).
 - Inpatient per diem is only reimbursed when a patient dies in a hospice facility. If a patient dies at home, the POS should be home, not the hospice facility.
- Hospice discharge date is eligible for payment and won't be considered as an exclusion.
- Make sure the discharge status reflects where the patient died.
- Bill with the hospice provider number and/or NPI referenced in the network attachment.
- Reimbursable allowable rate per unit will be rounded up to the second decimal amount (e.g., \$8.7110 would be \$8.72).
- In all cases, reimbursement for hospice services is based on:
 - Per diems allowed on a per day basis only.
 - The lesser of total covered charges or maximum allowable hospice fee schedule.

If you have any questions about billing for hospice services, please contact your Provider Network Manager.

Out-of-State (BlueCard) Authorizations

Out-of-state providers seeking prior authorization for our members can submit requests electronically through their normal provider portal. You can access the authorization from your local Blues Plan portal like you would for an in-state authorization. If the Blue Plan uses **Availity**, you can submit the authorization there by clicking on the **Authorization & Referrals** link. If a Blue Plan uses a different portal for authorizations, you should start the request on that portal.

To streamline the process and prevent the authorization from being delayed, please enter the ordering/requesting provider information and complete all necessary fields.

Upcoming Prior Authorization Changes

You can easily find the latest changes to prior authorizations under Upcoming Prior Authorization Changes in the News & Updates section of our **Documents & Forms** page. Prior authorization changes are published at least 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**).

BlueCare Tennessee

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

Process Reminders for *SelectKids* Members: Financial Responsibility and Obtaining Informed Consent

Foster parents aren't financially responsible for their foster child's medical care and shouldn't list themselves as the person responsible for payment on medical forms. If you have questions about payment, please contact the child's Department of Children's Services (DCS) representative.

DCS also facilitates the informed consent process for children and teens in state custody, so they get appropriate health care. This means a child's DCS representative may consent to care or delegate consent to the person who cares for the child daily (foster parents, legal guardians).

To review the related DCS policy, click [here](#). More information about obtaining informed consent is also available in our **PAM**.

Note: The information in this article only applies to *TennCareSelect*.

HIV Long-Acting Injectable

The human immunodeficiency virus (HIV) long-acting injectable, Cabenuva[®], is indicated for the treatment of HIV type 1 (HIV-1) in patients who are virologically suppressed (HIV-1 RNA less than 50 copies per mL). Patients who haven't had a prior virologic failure or baseline resistance to either cabotegravir or rilpivirine, are currently on a stable antiretroviral regimen, and have achieved a viral suppression for at least three months may benefit from an HIV long-acting injectable like Cabenuva[®].



Vision Screenings and Summer Eye Health Tips

July is Ultraviolet (UV) Safety Awareness Month, which makes it a great time to remind your patients about healthy vision tips.

Vision screenings are part of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visits. We cover vision screenings at no extra cost to members through age 20. Children and teens with BlueCare or TennCare*Select* coverage are eligible for preventive care on the same schedule recommended by the [American Academy of Pediatrics/Bright Futures periodicity schedule](#).

Along with their vision screening, you can share these summer eye health tips from the CDC with your patients:

- Wear sunglasses that block at least 90% of UVA and UVB radiation when outside. Hats also help protect eyes and skin from the sun. Remind them that even on cloudy days, UV rays are present and can be reflected from water.
- Limit screen time. Being out of school for the summer may mean more screen time at home. Try to limit time in front of screens and have children and teens take breaks frequently from screens when they're using them.
- Wear protective eyewear when doing yard work. If children or teens are helping with yardwork outside or playing nearby, safety glasses can help protect their eyes from debris.



Join Us for the August 2025 EPSDT Virtual Coding Workshop

Please plan to attend the second EPSDT coding workshop of 2025, scheduled for **Aug. 6 from 12 p.m. to 1:30 p.m. ET (11 a.m. to 12:30 p.m. CT)**. During the virtual session, we'll provide updates, and you'll hear from the Tennessee Chapter of the American Academy of Pediatrics.

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.

Help Prepare Your Patients for the New School Year

As the new school year approaches, consider using our Quality Care Rewards application in Availity to find out which patients are past due for checkups or vaccines they may need for school.

This is also a popular time for many patients to schedule sports physicals. Stand-alone sports physicals and their corresponding codes aren't covered for BlueCare Tennessee members. If a patient is due for a checkup, you can convert the sports physical to a well-child exam. EPSDT well-child exams satisfy all components of a sports physical. For more information and helpful tips, please see our [EPSDT Provider Tool Kit](#).

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

Tennessee Centers of Excellence: A Resource for Providers Caring for At-Risk Pediatric Patients

There are five Tennessee Centers of Excellence (COE), and they're designated tertiary care, academic medical centers, provider agencies and other partners with expertise in children's physical and behavioral health. These centers support children in DCS custody or who are at risk of entering custody.

The COEs have built relationships with DCS, local providers and other stakeholders, and provide treatment recommendations and consultations when children have complex needs and aren't responding to treatment as expected. They also provide direct evaluation and treatment services to children with complex medical and behavioral health needs.

Consider referring a patient in or at risk of DCS custody to one of the COEs when:

- The case is complex and there are diagnostic and mental health concerns.
- There are conflicting diagnoses among providers.
- A comprehensive review of the child's history (behavior, treatment or placement) would help determine the child's current needs.
- An evaluation or examination would add information needed for placement or treatment considerations.
- There's a concern about a developmental delay.
- There's a concern about the child's medications.

For more information about the COEs, including a list of centers and contact information, visit the [Division of TennCare's website](#).

Care After Hours: NurseLine

It's important to talk to foster parents about what to do when their child isn't feeling well late at night. Sometimes, parents' first reaction is to go to the ER, but it may be a non-emergency and could be solved faster and for less cost by calling the 24/7 NurseLine or visiting an urgent care clinic. If they're uncertain about the care their child needs, the 24/7 NurseLine has trained pediatric nurses who can coach them through symptoms, let them know whether they should treat them at home, see their PCP the next day, visit an urgent care center or go to the ER immediately.

Parents can call the NurseLine at **1-800-262-2873**. Nurses are available 24/7, including holidays. And all calls are no extra cost.

Transportation Scheduling Update

Your patients' BlueCare and TennCare*Select* benefits include transportation to and from covered medical and dental services and the pharmacy. Beginning **July 1, 2025**, your patients must schedule transportation to non-urgent medical and dental services at least two business days before their appointment. Previously, they had to request transportation 72 hours before their appointment.

Depending on their location and health needs, your patients' transportation services may include a bus pass, shared ride or mileage reimbursement. For more information about your patients' transportation benefits, visit bluecare.bcbst.com and select **Get a Ride**. You can also schedule transportation for a patient through Verida's [facility/provider portal](#). To get started using the portal, please call Verida at the toll-free customer service number for the patient's plan:

- BlueCare: **1-855-735-4660**
- TennCare*Select*: **1-866-473-7565**

BlueCare Plus Tennessee

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

Reminder: Complete the 2025 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](#).

BlueCare Plus Tennessee and Medicare Advantage

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

Authorization Needed for Radiopharmaceuticals

Beginning **July 1, 2025**, radiopharmaceutical codes A9607 and A9606 will require prior authorization for Medicare Advantage and BlueCare Plus Tennessee members. If you have questions, call us at your patient's plan number below:

- BlueCare Plus Tennessee: **1-800-299-1407**
- Medicare Advantage: **1-800-924-7141**



Medicare Advantage

This information applies to our BlueAdvantage (PPO)SM plans unless specifically identified below.

Complete 2025 Provider Assessment Forms (PAFs)

Don't forget to submit your PAFs for 2025. You can complete them during a face-to-face or telehealth visit with both audio and video components. You may complete the assessment forms in conjunction with a Medicare annual wellness visit or any other office visit type.

You can find and fill out the hierarchical chronic condition PAF in the Quality Care Rewards application in Availity. Be sure to keep a copy of the PAF in the patient's medical record.

Note: Office visit notes aren't accepted for PAFs.

Submit CPT® code 96161 and the appropriate visit Evaluation and Management code once the electronic PAF is submitted. No modifier is needed. Completed electronic PAFs are reimbursed at \$225 each for dates of service Jan. 1 through Dec. 31, 2025.

Please contact your Provider Quality Outreach Consultant if you need help with PAFs.

Quality Care Initiatives

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



Closing the Gap in Care: Follow-Up After Hospitalization for Mental Illness (FUH)

Timely follow-up care is critical for patients recovering from a hospitalization due to mental illness or intentional self-harm. Patients 6 years and older should receive a mental health follow-up visit within seven days of discharge and another within 30 days to support recovery and continuity of care.

Follow-up visits should happen after hospital discharge and may be conducted by a mental health practitioner, PCP, or via telehealth with any diagnosis of a mental health disorder.

For further details, please request a copy of the **Comprehensive Quality Measures Guide** by emailing the Commercial Quality Improvement team at GM_Commercial_Quality_Improvement@bcbst.com.

Promoting Well-Child Care: A Foundation for Lifelong Health

Well-child visits are essential for monitoring growth, development and overall health in children and adolescents. These visits help ensure timely immunizations, screenings and early intervention— helping to reduce unnecessary ER visits and supporting long-term well-being.

Key Measures to Know

- **Well-Child Visits in the First 30 Months of Life (W30):** Tracks well-child visits in the first 30 months of life.
- **Child and Adolescent Well-Care Visits (WCV):** Measures annual wellness visits for ages 3–21.
- **Weight Assessment for Children and Adolescents (WCC_BMI):** Ensures BMI percentiles are documented for ages 3–17.

Why It Matters

Well-care visits are preventive, often with no out-of-pocket cost, and are vital for all patients from birth through age 21.

Quick Tips for Providers

- Use the Quality Care Rewards application to identify and contact patients due for visits.
- Administer vaccines and combine visits when appropriate.
- Offer flexible hours and schedule future visits in advance.
- Convert sports physicals into well-child exams.
- Coordinate with other providers to ensure complete care.

By prioritizing these visits, providers can help children thrive—now and into adulthood.

For questions or more information, please email the Commercial Quality Improvement team at GM_Commercial_Quality_Improvement@bcbst.com.

Pharmacy

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

Step Therapy for Additional Medicare Part B Drugs

Medicare Advantage and BlueCare Plus Tennessee will implement step therapy for additional Part B drugs. This affects members who are new to therapy.

Prior authorization and step therapy aligns with CMS regulations and are required for the following Part B Eylea® biosimilars effective **July 1, 2025**:

- Ahzantive®
- Enzeevu™
- Opuviz™
- Pavblu™
- Yesafili™

Prior authorization and step therapy are required for the following Part B Soliris® biosimilars effective **July 1, 2025**:

- Bkenv®
- Epysqli®

You can find our Part B Step Therapy guide [here](#). If you have questions, please contact your Provider Network Manager.

Reminder for BlueCare Plus Tennessee Part B Drug Claims

For dates of service on or after **Jan. 1, 2024**, if you submit your BlueCare Plus Tennessee Part B drug claims through the member's pharmacy benefits manager, they'll be automatically forwarded to the member's assigned managed care organization (MCO) for processing.

If you haven't received notification that your claim has been processed within 60 days, or if you don't submit these claims through the member's pharmacy benefits manager, you should directly bill the claims to the member's assigned TennCare MCO.

As a reminder, Qualified Medical Beneficiary (QMB) members shouldn't be charged a copay or coinsurance on their Part B claims.



Removing Xhance® From Our Preferred Drug List

Beginning **July 1, 2025**, we're removing Xhance from our Preferred Drug List for Commercial lines of business. We'll send letters to members impacted by this change. If you have patients currently taking Xhance, please consider prescribing a covered alternative. To see the full list of covered drugs and preferred alternatives, please review the [2025 Preferred Formulary Guide](#). If you have questions, please contact your Provider Network Manager.

Nuedexta® Prior Authorization Requirement

Beginning **July 1, 2025**, we're adding a new prior authorization requirement for Nuedexta to confirm diagnosis for our Preferred Drug List for Commercial lines of business. Members impacted by this change will receive notification letters. Detailed criteria for this prior authorization can be found on the [Prior Authorization Criteria](#) page of our website. 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 specifically identified below. 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 TennCareSelect. 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



PROVIEW™

Be sure your **CAQH ProView™** profile is kept up to date at all times. We depend on this vital information.

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.

BlueCross BlueShield of Tennessee, Inc., BlueCare Tennessee, BlueCare Plus Tennessee and SecurityCare of Tennessee, Inc., Independent Licensees of the Blue Cross Blue Shield Association.

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 p.m. (ET)	
BlueCare	1-800-468-9736
TennCareSelect	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 PlusSM	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)	