AUGUST 2026

BlueAlert℠

Mission driven FOR 80 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 up to date in your **DataSpring** (formerly CAQH) account. This helps us reach you with important communications without delay.

INSIDE THIS ISSUE

Secure File Transfer Process (SFTP) Security Update: Action Needed

We're updating how data is securely sent to us. Password-based SFTP access will be replaced with **Secure Shell (SSH) key authentication** to better protect sensitive information.

What to Know

- **Deadline:** Jan. 31, 2027
- SSH keys will replace passwords for SFTP access

What You Need to Do

If you use SFTP with a password:

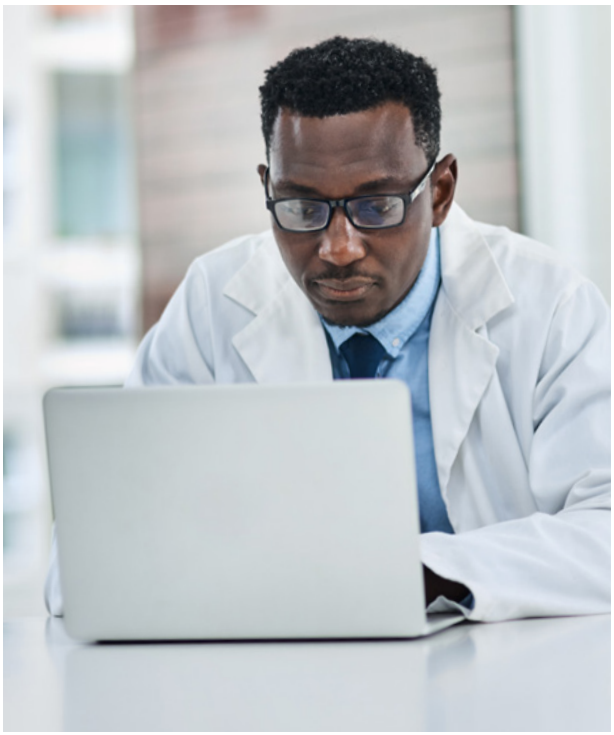
- Create an SSH key with your IT team or vendor
- Email your SFTP username and public key to **IO_SecureFile_Transfer@bcbst.com**

No Action Needed If

- You already use SSH keys, or
- You use the web portal for file access

Questions?

Contact **IO_SecureFile_Transfer@bcbst.com**.



Medical Record Submission Reminder

As a reminder, all contracted providers are required to cooperate with audit and medical record requests according to the terms of their provider agreement. This includes submitting complete and timely medical records when requested for Risk Adjustment Data Validation, requests from the Office of Inspector General and other regulatory or audit activities.

Failure to submit requested medical records may be considered non-compliant with contractual obligations and may result in corrective action, including removal from our networks.

We encourage providers to adopt appropriate processes for responding to future record requests. If there are circumstances that could impact your ability to comply (such as practice closure or record transfers), please notify your Network Manager in advance.

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 written 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 check your Provider Administration Manual (PAM). You can also find additional information in the FAQs document **here**.

Update Your Contact Preference in Availity®

To make sure you receive important provider enrollment and contracting information as soon as it's available, please update your **contracting** contact preference in Availity.

When you choose email as your Contracting contact preference, you'll receive email updates about contracts, fee schedules, Provider Administration Manuals (PAMs), medical policies and annual performance ratings.

To update your preference, log in to BlueCross Payer Spaces in Availity. Open the **Contact Preferences & Communication Viewer** and select email for Contracting communications. Before saving your changes, be sure to add or confirm a contact name and email address.

If you need help, you can find a **Contact Preference Quick Reference Guide** under the **Payer Spaces Resources** tab. Please note, changes may not take effect right away, and you may still get some mail during the transition.

For extra help, contact **eBusiness Technical Support** at **423-535-5717**, **option 2**.

Inquiries, Reconsiderations and Appeals Must Be Submitted in Availity

Effective **April 1, 2026**, all providers must submit inquiries, reconsiderations and appeals through our claims dispute tool in Availity.

What you need to know:

- We no longer accept submissions by fax, mail or email.
- This applies to:
  - In-network providers.*
  - Out-of-network providers with a practicing address in Tennessee.**
- Forms are no longer required for reconsiderations or appeals submitted through Availity.
  - You must still enter the reason for your request in the appropriate Availity field.
  - Additionally, if you received a request to submit medical records, please follow the instructions included in the notification.
- If you identify an overpayment, submit it as a general inquiry in Availity.
  - Use this process until we announce a permanent overpayment submission option.
  - Previously, the "Think you have an overpayment" form was used.

For more information, please see our additional resources in our Payer Spaces in Availity or contact your **eBusiness Network Manager**.

*Please note, this doesn't apply to inquiries, reconsiderations or appeals for routine dental service claims performed by dental providers. It also doesn't apply to Utilization Management denials.

**Out-of-network providers who wish to submit an inquiry, reconsideration or appeal for review must still submit through Availity.

About the Provider Exclusion Screening Process

The health and safety of our members and your employees is important, which is why we'd like to remind you of your contractual obligation to screen all employees, agents and contractors (the "Exclusion Screening Process") against the exclusion lists.

You also need to conduct criminal background checks and registry checks in accordance with state law to determine whether any of them are ineligible persons, and therefore, excluded from participation in Medicare or Medicaid programs. At minimum, registry and exclusion checks must include the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, Social Security Death Master File, HHS-OIG List of Excluded Individuals and Entities (LEIE), System for Award Management (SAM), and the Tennessee Terminated Providers List (TTPL).

The screenings should be conducted prior to hiring employees or contracting with individuals and entities, and every month following for HHS-OIG LEIE, SAM and TTPL. Providers are also required to have employees and contractors disclose if they're ineligible persons prior to providing any services on behalf of the provider.

If you have questions, please refer to the "Provider Networks – Federal Exclusion Screening Requirement" section of the **commercial** and **BlueCare Tennessee** Provider Administration Manuals.

Updates to the Durable Medical Equipment Network

As of **March 6, 2026**, we've contracted with CareCentrix to manage our durable medical equipment (DME) network. This change supports our broader efforts to address rising health care costs while maintaining members' access to the DME services and products you currently order for your patients.

For DME items that **don't** require prior authorization, BlueCross participating providers should place orders through the DME Navigator portal, which Parachute Health manages. You can access the portal via a tile in Availity. Once in DME Navigator, you can select an in-network DME supplier.

For DME requiring prior authorization, continue following the current BlueCross prior authorization process through Availity. Or, if you send an order directly to an in-network DME supplier, the supplier will initiate the prior authorization request.

We'll continue reviewing DME prior authorization requests in-house through **the first half of 2027**. After that, CareCentrix will begin reviewing and approving prior authorization requests for all networks. That process will start either in Availity or the DME Navigator portal. We'll share more information about that process once we have an implementation date for this transition.

If you have questions, please contact your Provider Network Manager.

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, regional commercial networks.

BH providers are contracted into the BH Comprehensive Network, which automatically includes all commercial networks (P, S, L and E). These providers are 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.

Example 1:

- The member's policy uses Network S.
- The health care group practice is contracted only in Network P and the BH Comprehensive Network.
- 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.

Example 2:

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

Updates at a Glance: What's New and What's Coming

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 **Documents & Forms** page on **provider.bcbst.com**. Updates are located under **Code Edits/Code Updates** in the **News & Updates** 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.

Provider Options After Authorization Denial

Receiving a denial can be challenging and may raise questions about next steps. If you disagree with a denial for authorization of services, it's important to know the appropriate next steps. Choosing the correct option ensures you receive the quickest response for you and the member.

1. If you have clinical information that wasn't included in your initial submission, you can submit it for a utilization management reconsideration through Availity or by fax to **800-292-5311**.
2. If you'd like to discuss the request with a physician reviewer, call Provider Services at **800-924-7141**.
3. You can appeal the denial by following these steps:

   Has the member received the care you want to appeal?

   - **No** – Submit your appeal directly to the Division of TennCare. The requirements and instructions for how to submit this appeal on behalf of the member are listed in the denial letter addressed to the member.
   - **Yes** – Fax your request to **888-357-1916**.*

*If the member hasn't received the care you're trying to appeal, submitting to this fax number can delay your appeal as it'll be returned with instructions to submit to TennCare.

BlueCare Tennessee High-Cost Lab Prior Authorization List Update

Starting **Sept. 1, 2026**, prior authorization will be required for the following laboratory and genetic testing codes for BlueCare Tennessee members.

Code	Code Description
81416	Exome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator exome (e.g., parents, siblings) (List separately in addition to code for primary procedure)
81425	Genome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis
81415	Exome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis
81426	Genome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator genome (e.g., parents, siblings) (List separately in addition to code for primary procedure)
81464	Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid (e.g., plasma), interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis, copy number variants, microsatellite instability, tumor mutation burden and rearrangements
81459	Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis, copy number variants, microsatellite instability, tumor mutation burden and rearrangements
81456	Solid organ or hematolymphoid neoplasm or disorder, 51 or greater genes, genomic sequence analysis panel, interrogation for sequence variants and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; RNA analysis
81460	Whole mitochondrial genome (e.g., Leigh syndrome, mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes [MELAS], myoclonic epilepsy with ragged-red fibers [MERFF], neuropathy, ataxia, and retinitis pigmentosa [NARP], Leber hereditary optic neuropathy [LHON]), genomic sequence, must include sequence analysis of entire mitochondrial genome with heteroplasmy detection
0473U	Oncology (solid tumor), next-generation sequencing (NGS) of DNA from formalin-fixed paraffin-embedded (FFPE) tissue with comparative sequence analysis from a matched normal specimen (blood or saliva), 648 genes, interrogation for sequence variants, insertion and deletion alterations, copy number variants, rearrangements, microsatellite instability, and tumor-mutation burden
0172U	Oncology (solid tumor as indicated by the label), somatic mutation analysis of BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) and analysis of homologous recombination deficiency pathways, DNA, formalin-fixed paraffin-embedded tissue, algorithm quantifying tumor genomic instability score

There are three ways to submit these requests:

- **Availity.com**
- Phone: **888-423-0131**
- Fax: **800-292-5311**

If you have questions about submitting a prior authorization in Availity, please call **423-535-5717**, **option 2**, or contact your **eBusiness Network Manager**.

We're updating the **High-Cost Lab Prior Authorization List** with this information.

New Obesity Model of Care Program

BlueCare Tennessee is launching a new Obesity Model of Care program to help support TennCare patients using incretin-based weight management therapies, including GLP-1 and GLP-1/GIP agents.

This model offers wrap-around support to help patients get the most benefit from treatment. You can help by connecting patients with available services, including medical nutrition therapy and behavioral health support. Registered dietitian services are a covered benefit for TennCare patients, and many services may be available through telehealth. We list in-network registered dietitians in the BlueCare Tennessee provider directory.

Behavioral health needs, including disordered eating, are common among patients with obesity and may affect treatment safety and outcomes. A new provider guide includes evidence-based screening tools to help identify disordered eating and connect patients with appropriate support.

Please review **the guide** for more information about available resources and referral options.

Reimbursement Update: Services Provided by Physical Therapist and Occupational Therapy Assistants

We follow CMS guidelines for physical and occupational therapy services furnished in whole or in part by physical therapy assistants (PTAs) and occupational therapy assistants (OTAs). Beginning **Oct. 1, 2026**, reimbursement for these services will be limited to 85% of the applicable fee schedule.

When submitting claims for these services, please make sure to include the applicable modifier:

- **CQ modifier:** Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
- **CO modifier:** Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant

Please note, all other billing and processing guidelines associated with physical and occupational therapy services apply, including but not limited to, prior authorization requirements, coordination of benefits and timely filing. Additionally, all claims submitted to BlueCare Tennessee are subject to retrospective claims review and possible recovery.

EPSDT Screening Guidelines for Children in State Custody

Children and teens must have a medical screening exam within 72 hours of entering DCS custody. The purpose of the 72-hour screening is to identify, treat and provide caregivers with education about a child's acute or chronic medical or behavioral health conditions.

They should then have an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) checkup within 30 days. The exam performed within the first 72 hours may serve as the EPSDT exam if it contains all necessary components. Following these exams, children and teens should continue getting preventive services according to the **Bright Futures/American Academy of Pediatrics Periodicity Schedule**.

Previously, most kids and adolescents in state custody got their initial and subsequent EPSDT screenings at local health departments. To help promote continuity of care, primary care providers (PCPs) can now perform the 72-hour initial exam, 30-day EPSDT exam and any subsequent EPSDT screenings. If their PCP isn't available, children may visit a local health department for these services.

Schedule Transportation for Your Patients After Hospital Discharge

Verida has introduced a new feature in its Facility Portal that allows facilities to schedule non-emergency medical transportation (NEMT) for hospital discharges. The portal is monitored 24/7 to ensure timely coordination and support.

To access this feature, you must create an account with Verida. If you're interested in scheduling hospital discharges through the portal, please contact Heath Williams at **hwilliams@verida.com** or Kevin Reeves at **wreeves@verida.com**. They can help you set up your account. For help using the platform, please refer to the **Verida Facility Portal Hospital Discharge Reference Guide**.

Note: This doesn't apply to CoverKids members.

Using Technology to Boost EPSDT Rates

Many members find electronic communications more convenient than paper mail. You can help us make sure your patients are getting the screenings and treatment they need by encouraging them to opt in to Relay messaging from us.

Relay messaging begins with a text message that directs our members to a personalized message feed containing important updates about their health plan, screening reminders and more. Members can sign up for these updates at **bluecare.bcbst.com/relay-enroll**.

Here are a few other ways you can use digital tools to help you care for members who may be past due for their EPSDT exams:

- Our Quality Care Rewards application in Availity. Open the application, choose **Contract** view and then **BlueCare EPSDT**.
- Most EMR/EHR systems offer tools to schedule visits and notify patients when they may be overdue for a screening.

Connecting Members to Breastfeeding Resources and Support

Breastfeeding can provide important health benefits for both babies and parents. Since August is National Breastfeeding Month, now's a good time to refresh your knowledge of breastfeeding resources available to BlueCare, TennCare*Select* and CoverKids members.

Breastfeeding Benefits for Members

BlueCare, TennCare*Select* and CoverKids members have access to lactation benefits, including medically appropriate lactation consultant services from in-network providers during pregnancy and the extended postpartum period. Members can access these services through telehealth or in-person visits.

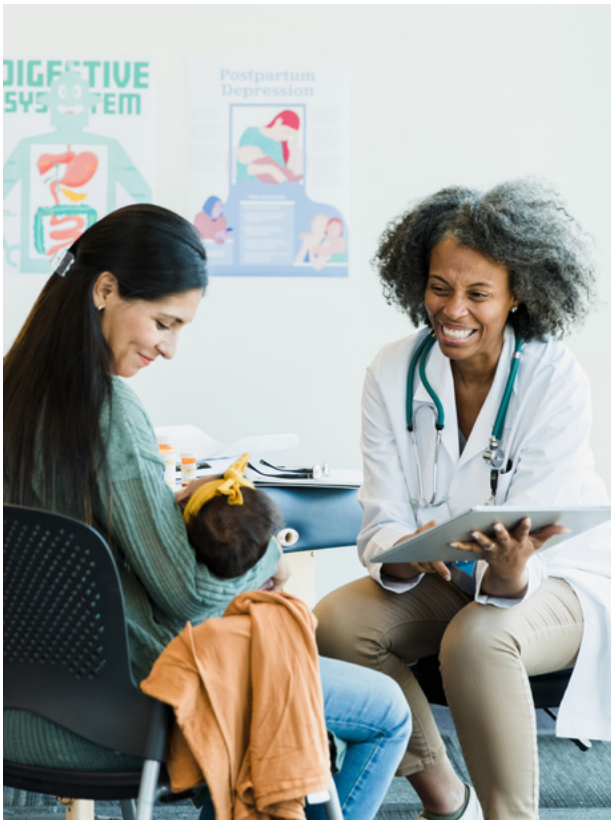
You can learn more about those benefits **here**.

How You Can Help

You play an important role in helping families meet their breastfeeding needs. Recent CDC data show that while many families begin breastfeeding, rates decline by six months. This suggests that ongoing support and education can make a meaningful difference. Families may face challenges like:

- Limited support from family members and caregivers
- No opportunities to connect with other breastfeeding parents
- Inconsistent or outdated breastfeeding information
- Challenges to get started with successful breastfeeding
- Difficulty breastfeeding or expressing milk after returning to work

Actions like discussing breastfeeding early, connecting members with lactation support and encouraging family involvement can help address these barriers.



Additional Resources

- **Tennessee Breastfeeding Hotline**
- **International Lactation Consultant Association**
- **Healthy Children Project, Inc. Lactation Courses**
- **Safety in Maternity Care | Breastfeeding | CDC**

Important Reminders for Filing Crossover Claims

To help us correctly identify whether a claim is a crossover (cost share) or a secondary claim (including Medicare non-covered services), please follow these guidelines:

- Use the correct insurance indicator and policy number.
- Crossover claims are identified by the claim filing indicator located in the **2000B Loop (Subscriber Info)** section of your electronic claim.
- Use **"16"** in **SBR09** to show the claim is secondary to Medicare, a Dual Eligible Special Needs Plan or a Medicare Advantage plan. For all secondary non-crossover claims, do not use "16" in the SBR09 for the 2000B Loop.
- The **2320 Loop (Other Subscriber Info)** includes the patient's other insurance. Continue using **MA, MB, OF** or **16** in SBR09 for Medicare or the appropriate commercial indicator (e.g., 12, BL, CI, HM) depending on the primary insurance type – just like you do today. You can view a full list of indicators **here**.

Using the correct indicators helps prevent claim denials, avoid payment delays and ensure accurate coordination of benefits.

Deadlines for Submitting Crossover Claims

Crossover claims should be limited to certain situations and should only occur after they've allowed at least 60 days for Medicare or Dual Special Needs Plans (D-SNP) to cross the claim to BlueCare Tennessee.

Providers have 365 days from the date of service or 180 days from the paid date on the Medicare MSN-D-SNP EOB, whichever is greater, to submit a claim for cost-share reimbursement.

After the initial filing (within those timeframes), if BlueCare Tennessee rejects, returns or denies the claim, providers must resubmit the corrected claim within six months from the rejected, returned or denied date.

Save the Date: EPSDT Virtual Workshop on Aug. 20

We're hosting the second EPSDT Virtual Workshop of 2026 on **Aug. 20** from **noon-1:30 p.m. ET**. If you couldn't attend our workshop in June, please join us. 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** to fill out the registration form and save your spot.

We look forward to connecting with you.

BlueCare Plus Tennessee

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

Complete the 2026 Special Needs Plans 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.

Quality Measure Corner: Childhood and Adolescent Immunizations

Since the COVID-19 pandemic, U.S. childhood immunization rates have dropped below herd-immunity levels, with exemptions at all-time highs. The CDC reports rising outbreaks of measles and pertussis tied to lower vaccination rates, including the first measles deaths in more than ten years. HEDIS® measures address immunizations recommended by the American Academy of Pediatrics (AAP) for children and adolescents to prevent potentially serious illnesses.

The CIS-E HEDIS® measure tracks the percentage of children by age 2 who received these vaccines:

- Four diphtheria, tetanus and acellular pertussis (DTaP)
- Three polio (IPV)
- One measles, mumps and rubella (MMR)
- Three haemophilus influenza type B (HiB)
- Three hepatitis B (HepB)
- One chicken pox (VZV)
- Four pneumococcal conjugate (PCV)
- One hepatitis A (HepA)
- Two or three rotavirus (RV)
- Two influenza (flu)

The IMA-E HEDIS® measure tracks adolescents by age 13 who received the following vaccines:

- One dose of meningococcal
- One tetanus, diphtheria toxoids and acellular pertussis (Tdap)
- Complete human papillomavirus (HPV) vaccine series by their 13th birthday

These immunizations must be given before each child's 2nd or 13th birthday, respectively, to meet current NCQA HEDIS® standards.

We cover these vaccines at no cost and support collaborative decision-making regarding vaccination between health care providers and their patients.

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

THCII Episodes of Care Quarterly Report Release

Interim and final performance reports for BlueCare Episodes of Care Quarterbacks will be available Aug. 20, 2026.

If you're having trouble accessing your quarterly report, please call **423-535-5717** and press **option 2**.
Or you can email **eBusiness_Service@bcbst.com**.

Note: This article only applies to providers in our BlueCare network.

Review the 2026 BlueCare Tennessee Quality Measures Guide

The updated BlueCare Tennessee Quality Measures Guide is now available online. View the guide on our **Quality Care Initiatives** page under **Patient-Centered Medical Home and Tennessee Health Link**.

The guide includes information about specific quality measures and tips to help you maximize your performance in our quality programs. We hope you find it helpful.

Pharmacy

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

Medicare GLP-1 Bridge Program

Providers **shouldn't submit GLP-1 Bridge program prior authorizations to BlueCross**. The Medicare GLP-1 Bridge program is administered separately from Medicare Part D, and all prior authorizations, coverage determinations and eligibility questions should follow the Centers for Medicaid & Medicare (CMS) process.

CMS uses **Humana** as its vendor to administer the program, process claims and review prior authorizations. When prescribing a medication through the program, include **"Send to Bridge for Weight Management"** on the prescription. The pharmacy will initiate the prior authorization request.

If a GLP-1 Bridge program prior authorization is submitted to us, we'll redirect you to the CMS process. For questions about eligibility, coverage reviews or authorization status, contact CMS at **glp1demo@cms.hhs.gov**.

Concurrent Prescribing Alert: Opioids with Benzodiazepines or Antipsychotics

The concurrent use of opioids with benzodiazepines and certain antipsychotics significantly increases the risk of sedation, respiratory depression, overdose, and death due to additive central nervous system effects. These combinations carry FDA boxed warnings, with heightened risk observed when benzodiazepines or sedating antipsychotics are involved.

Under the SUPPORT Act (Section 1004), Medicaid programs are required to implement drug utilization review (DUR) safety edits and monitoring to identify high-risk prescribing patterns, including these medication combinations.

Clinical reminders:

- Avoid co-prescribing when possible.
- Use the lowest effective doses and shortest durations if combination therapy is necessary.
- Monitor closely for signs of sedation and respiratory compromise.
- Consider naloxone for patients at increased risk.
- Review the patient's full medication profile and assess risk versus benefit.
- Consider safer therapeutic alternatives when appropriate.
- Educate patients on overdose risk and signs of respiratory depression.

Careful coordination across prescribers and pharmacies, along with use of DUR alerts, is essential to reduce preventable adverse events.

Updates to Medical Policies for Select Specialty Medications

BlueCare Tennessee is updating medical policies that apply to the following medications:

- Vyepti®
- Exondys 51®
- Tepezza®

The updated policies will be available beginning August 1 under the Specialty Care tab on the **BlueCare Tennessee provider tools and resources page**.

These policy changes will take effect on **Sept. 30, 2026**.

What This Means for You

BlueCare Tennessee medical policies may differ from those in the broader Medical Policy Manual. When reviewing coverage criteria:

- Policies labeled **"Applies to BlueCare Only"** are specific to BlueCare Tennessee members.
- Policies labeled **"Does Not Apply to BlueCare"** apply to other lines of business.

To ensure accurate coverage determinations, please review the appropriate policy and label when prescribing or requesting authorization for these medications.

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 **800-468-9698** for BlueCare, **888-325-8386** for CoverKids or **800-263-5479** for TennCare*Select*. For TTY help call **771** and ask for **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	800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. ET	
Commercial UM	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	800-572-1003
Monday-Friday, 8 a.m. to 6 pm. ET	
BlueCare	800-468-9736
TennCare*Select*	800-276-1978
CoverKids	800-924-7141
CHOICES	888-747-8955
ECF CHOICES	888-747-8955
Monday–Friday, 8 a.m. to 6 p.m. ET	
BlueCare Plus℠	800-299-1407
Seven days/week, 8 a.m. to 6 p.m. ET	
***Select* Community**	800-292-8196
Monday-Friday, 8 a.m. to 6 p.m. ET	
BlueCard	
Benefits & Eligibility	800-676-2583
All other inquiries	800-705-0391
Monday–Friday, 8 a.m. to 6 p.m. ET	
BlueAdvantage	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-Friday, 8 a.m. to 6 p.m. ET	
Verida	423-893-8282

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 **800-924-7141**.