

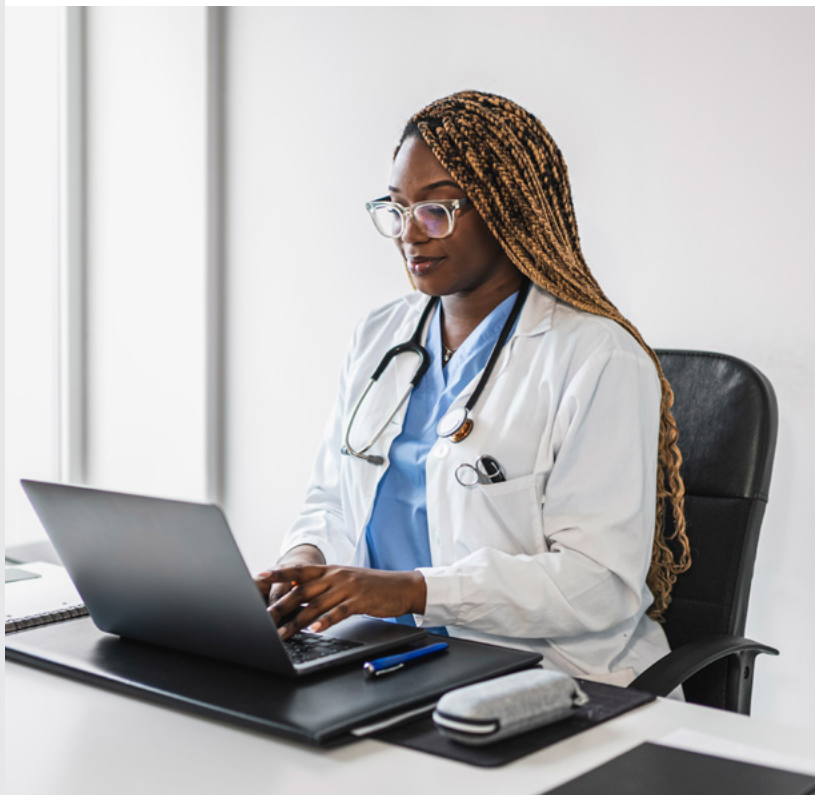
# BlueAlert<sup>SM</sup>



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 CAQH account. This helps us reach you with important communications without delay.

### INSIDE THIS ISSUE

#### BlueCross BlueShield of Tennessee, Inc.

- [Keep Your Information Current](#)
- [Accurate Autism Diagnosis: What Providers Need to Know](#)
- [Medical Record Submission Reminder](#)
- [Change of Ownership Reminder](#)
- [Update Your Contact Preference in Availity®](#)
- [Inquiries, Reconsiderations and Appeals Must Be Submitted in Availity](#)
- [2027 Maternity Care Services Code Changes](#)
- [Grant Opportunities for Rural Health Funding](#)
- [Updates to the Durable Medical Equipment Network](#)

#### Commercial

- [Understanding the Behavioral Health \(BH\) Comprehensive Network](#)
- [Updates at a Glance: What's New and What's Coming](#)

#### BlueCare Tennessee

- [View Important Information Digitally](#)
- [New Guidance for Stand-Alone Vaccine Counseling](#)
- [Tennessee Centers of Excellence: A Resource for Providers Caring for At-Risk Pediatric Patients](#)
- [Financial Responsibility and Getting Informed Consent for \*SelectKids\* Members](#)
- [Using EPSDT Visits for Sports Physicals](#)
- [Mileage Reimbursement for BlueCare Tennessee Members](#)
- [Important Reminders for Filing Crossover Claims](#)

#### BlueCare Plus Tennessee

- [Updated IM and DND Notices](#)
- [CMS Releases Updated Medicare Outpatient Observation Notice \(MOON\)](#)
- [Complete the 2026 Special Needs Plans Model of Care \(MOC\) Training](#)

#### Quality Corner

- [Colorectal Cancer Screening Update](#)
- [Care for Older Adults \(COA\): Medication Review and Functional Status](#)
- [Call Us First: Guiding Patients to the Right Crisis Care](#)

#### Pharmacy

- [Step Therapy for Additional Medicare Part B Drugs](#)
- [Mid-Year Preferred Formulary Changes Effective July 1](#)
- [Refer to the TennCare Pharmacy Benefit Manager for Important Updates](#)

## Accurate Autism Diagnosis: What Providers Need to Know

A valid autism spectrum disorder (ASD) diagnosis must meet DSM-5 criteria, including both persistent deficits in social communication **and** restricted or repetitive behaviors, with symptoms present in early development and causing functional impairment.

Diagnosis shouldn't be based on a single screening or visit. Screening tools identify risk but don't confirm ASD.

A comprehensive evaluation should include developmental history, direct observation and use of validated assessment tools.

Clear documentation is essential. Providers should outline which DSM criteria are met, supporting clinical evidence, functional impact and differential diagnoses considered.

Accurate, well-documented diagnoses support appropriate care (therapies), improve outcomes and ensure compliance.



## 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 Provider 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.
  - You must still enter the reason for your request in the appropriate Availity field.
- 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.

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

## 2027 Maternity Care Services Code Changes

The American Medical Association CPT® Editorial Panel has approved a significant restructuring of maternity care service codes. Beginning **Jan. 1, 2027**, maternity care will transition from global coding to a more granular, service-level approach across antepartum, labor management, delivery and postpartum phases. As part of this change, the Editorial Panel has deleted 17 CPT® codes, added 12 codes, revised six codes, and updated related guidelines for improved alignment between clinical work, documentation and reporting.

You can view the 2027 code set and new guidance [here](#). The American College of Obstetricians and Gynecologists has also developed helpful [information for providers](#), and we'll share more information to help you prepare for this change in future issues of BlueAlert.

## Grant Opportunities for Rural Health Funding

Tennessee is participating in the CMS Rural Health Transformation Program, a federal initiative to help strengthen rural health systems across the nation. This program includes competitive grants for providers aimed at improving care access, quality and sustainability in rural communities. The Tennessee Department of Health is currently accepting applications for these funding opportunities:

Grant	Open Period
Chronic Disease Prevention	Open through July 6, 2026
Service Line and Co-Location	Open through July 13, 2026
Memory Care Assessment Network (MCAN)	Open through July 20, 2026
Health Tech Innovation	Open through July 27, 2026
Make Rural Tennessee Healthy Again (MaRTHA)	July 2 to Aug. 3, 2026



For more information about the Rural Health Transformation Program and how to apply for these grants, please visit the Tennessee Department of Health Rural Health Access for Tennessee's Future [webpage](#).

## 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 summer**. 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<sup>SM</sup>, Blue Network S<sup>SM</sup>, Blue Network L<sup>SM</sup> and Blue Network E<sup>SM</sup> unless specifically identified below.*

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## 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](mailto:medical_policy@bcbst.com).

Update Type	Availability	Where to Find It
Coding Updates	60 days before the effective date	Go to the <a href="#">Documents &amp; Forms</a> page on <a href="http://provider.bcbst.com">provider.bcbst.com</a> . Updates are located under <b>Code Edits/Code Updates</b> in the <b>News &amp; Updates</b> section.
Lab Testing Policies	60 days before the effective date	Go to the <a href="#">Documents &amp; Forms</a> page on <a href="http://provider.bcbst.com">provider.bcbst.com</a> .
Upcoming Prior Authorization Changes	60 days before the effective date	Go to the <a href="#">Documents &amp; Forms</a> page on <a href="http://provider.bcbst.com">provider.bcbst.com</a> . Updates are located under <b>Upcoming Prior Authorization Changes</b> in the <b>News &amp; Updates</b> section.
Pharmacy Updates	Updated as needed	Download a summary of select upcoming drug prior authorization criteria changes <a href="#">here</a> .
Medical Policy Updates	60 days before the effective date	Go to the <b>Manuals, Policies &amp; Guidelines</b> page on <a href="http://provider.bcbst.com">provider.bcbst.com</a> . Updates are located under <a href="#">Coverage</a> .

## BlueCare Tennessee

*This information applies to BlueCare<sup>SM</sup>, TennCareSelect and CoverKids plans unless specifically identified below.*

### View Important Information Digitally

Later this month, certain BlueCare Tennessee provider materials will transition to a digital-first delivery model. If you've signed up for emails from us, you'll get these communications electronically.

We're making this change to improve accessibility and support timely communication. You'll get faster access to updates and fewer printed letters.

#### Accessing Your Materials

We'll begin sending communications electronically in late July 2026. If you have a document to review, you'll get an email directing you to view it in your **Contact Preferences & Communications Viewer** in Availity. See the Contact Preferences & Communications Viewer Quick Reference Guide under the Payer Spaces Resources tab if you have questions about using this tool.

We recommend bookmarking the link to Availity and making sure all clinical, billing and administrative staff have an account and know where to find materials.

#### Sign Up Today

If you haven't already signed up for emails from us, you can update your communication preferences in Availity. Please opt in to get electronic updates for all contact types.

For help using Availity, please contact your [eBusiness Network Manager](#) or call **423-535-5717, option 2**.

## New Guidance for Stand-Alone Vaccine Counseling

The Division of TennCare recently updated its stand-alone vaccine counseling guidance and relevant CPT® codes. Please review the [New Stand-Alone Immunization/Vaccine Counseling Codes \(Revision to Memo dated May 4, 2023\) memo](#) for the most up-to-date guidance and billing information. If you have questions, you can call our provider service line.

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

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

The COEs have built relationships with DCS, local providers and other stakeholders. They 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 a COE 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 exam 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, visit the [Division of TennCare's website](#).

## Financial Responsibility and Getting Informed Consent for *SelectKids* Members

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 DCS representative.

DCS also facilitates the informed consent process for children and teens in state custody. 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). More information about getting informed consent is available in our [PAM](#).

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



## Using EPSDT Visits for Sports Physicals

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) well-child visits are a key part of preventive care. They provide comprehensive screenings and assessments for members ages 3 to 20. As the school year approaches, many families are scheduling these visits. This is also a good time to use the Quality Care Rewards application in Availity to find out which patients are past due for checkups or vaccines they may need for school.

July is a popular time for patients to request sports physicals. For BlueCare Tennessee members, stand-alone sports physicals aren't covered. However, if a patient is due for a checkup, you can complete an EPSDT well-child exam, which also meets sports physical requirements.

Encourage patients to bring sports physical forms to the visit to streamline documentation and avoid separate appointments. Using EPSDT visits in this way helps improve access, close care gaps and support better health outcomes.

**Note:** This doesn't apply to CoverKids members.

## Mileage Reimbursement for BlueCare Tennessee Members

We contract with Verida to help with non-emergency medical transportation to and from covered TennCare services. Depending on a member's location, transportation options may include a shared ride service, such as Lyft, multiple passengers in the vehicle, bus passes or mileage reimbursement.

Mileage reimbursement is a convenient option for members who have access to a vehicle or a friend or relative who's willing to drive them to their appointment. Members who choose mileage reimbursement will receive a form that you'll need to sign confirming they visited your office. They'll then send the form to Verida, which will refund them for the miles traveled.

**Note:** This doesn't apply to CoverKids members.

## 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 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.

# BlueCare Plus Tennessee

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

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## Updated IM and DND Notices

The Office of Management and Budget (OMB) has approved updated Important Message from Medicare (IM) and Detailed Notice of Discharge (DND) notices.

They're effective now and expire **March 31, 2029**. Updated forms can be found on the [CMS website](#).



## CMS Releases Updated Medicare Outpatient Observation Notice (MOON)

The OMB has approved the CMS-updated MOON. The revised form features improvements to readability and design. It's effective immediately and expires on **Feb. 28, 2029**.

You must begin using the updated version. You're also required to deliver a MOON to Medicare beneficiaries and let them know they're outpatients receiving observation services—not inpatients at a hospital or critical access hospital.

For more instructions, visit the CMS [Claims Processing Manual \(Pub. 10004\), Chapter 30, Section 400](#).

## 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.*

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## Colorectal Cancer Screening Update

While CMS covers the Shield™ blood-based colorectal cancer screening test from Guardant Health, it isn't an approved method for gap closure under current quality programs. It also has an approximate cost of \$1,400, which may result in patient cost share.

To close colorectal cancer screening gaps, please use accepted screening methods, such as colonoscopies or approved stool tests.

For questions about quality requirements, please refer to our [Quality Information Guides](#) or contact your quality consultant.

## Care for Older Adults (COA): Medication Review and Functional Status

The COA measure is a National Committee for Quality Assurance (NCQA) HEDIS® measure used by CMS in the Medicare Advantage Star Ratings program. It applies to patients ages 66 and older and evaluates whether they receive key elements of age-appropriate care during the measurement year.

To meet COA requirements, complete and document two components: a medication review and a functional status assessment. These support patient safety, care planning and independence for Medicare Advantage Chronic Condition Special Needs Plan (C-SNP) and BlueCare Plus Tennessee (D-SNP) members. Be sure to document both at least once each measurement year.

### Medication Review Requirements:

- Review a complete medication list. This should include prescription drugs, over-the-counter products, vitamins and supplements.
- Document the medication name, dose, frequency and indication (medication name alone is acceptable).
- Note "Patient takes no medications" when applicable.
- Make sure documentation is signed and dated by a prescribing provider or clinical pharmacist.

### Functional Status Assessment Requirements (one of the following):

- At least five Activities of Daily Living (ADLs)
- At least four Instrumental Activities of Daily Living (IADLs)
- A standardized functional status assessment tool

Assessments should reflect your patient's current functional ability and inform care planning.

Remember to submit claims with accurate codes to help improve performance. For functional status assessments, use 99483 and 1170F. For medication reviews, use 90863, 99483, 99605, 99606 and 1160F.

Routine medication reviews and functional assessments can help identify safety risks, support independence, close care gaps, and improve outcomes and Medicare Advantage and BlueCare Plus Tennessee Star Ratings.

## Call Us First: Guiding Patients to the Right Crisis Care

Behavioral health providers are on the front line of helping patients access the right level of care during times of crisis. While ERs and inpatient hospitalization remain essential for high-risk situations, not every behavioral health need requires that level of intervention.

Providers can manage many crises in less intensive settings like outpatient care, same-day access or crisis evaluation. These options support continuity of care, reduce unnecessary disruption and often lead to better patient experiences.

### ER or inpatient care may not be necessary when:

- Symptoms are worsening but there's no immediate safety risk.
- Medication questions or concerns don't involve acute complications.
- Support can de-escalate anxiety, mood or situational stress.
- The need is urgent, but appropriate for next-day or rapid outpatient follow-up.

Tennessee's crisis continuum offers additional options, including Crisis Stabilization Units (CSUs). These short-term, non-hospital settings provide 24/7 support for individuals who need more than outpatient care but don't require hospitalization. CSUs help patients stabilize safely and transition back to ongoing treatment with minimal disruption.

Providers can play a key role in guiding patients by establishing a "call us first" approach. Encouraging patients to contact their care team before seeking emergency services allows for timely triage, clinical guidance and connection to the most appropriate resource. You can direct patients to resources like outpatient follow-up, mobile crisis, walk-in services, CSU placement or escalate when necessary.

Clear and consistent patient education is critical. Reinforcing simple messages during routine visits, sharing after-hours contact information and incorporating crisis planning into care can empower patients to make informed decisions.

By helping patients access the right care at the right time, providers improve quality and efficiency by reducing avoidable ER visits, saving access for higher-acuity needs and strengthening outcomes across Tennessee's behavioral health system.

Source: Tennessee Department of Mental Health and Substance Abuse Services [Crisis Services Continuum](#)

## Pharmacy

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

### Step Therapy for Additional Medicare Part B Drugs

Effective **July 1, 2026**, BlueAdvantage and BlueCare Plus Tennessee will follow CMS guidelines and apply step therapy to additional Medicare Part B drugs. This update applies only to members who are new to therapy.

Prior authorization and step therapy will be required for these Part B drugs:

- Armlupeg
- Boncresa
- infliximab abda
- Jubereq
- Osvyrti
- Oziltus
- ustekinumab auub

[Click here](#) to view requirements and preferred options.

If you have questions or need support, our provider service team is here to help.



## Mid-Year Preferred Formulary Changes Effective July 1

Effective **July 1, 2026**, we made a few changes to the Preferred Formulary. These changes included:

- Removing certain drugs
- Adding quantity limits to certain drugs
- Adding new prior authorization requirements to certain drugs

You can find the full list of changes on [bcbst.com/pharmacy](https://bcbst.com/pharmacy). Please check the mid-year **What's Changing** document for more information.

## Refer to the TennCare Pharmacy Benefit Manager for Important Updates

Please [click here](#) to review important notices about prescribing changes, authorization guidelines and other items related to the TennCare Pharmacy Program.

BlueCross BlueShield of Tennessee, Inc., BlueCare Tennessee and their licensed health plan and insurance company affiliates comply with the applicable federal and state laws, rules and regulations and does not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability. If a member or participant needs language, communication or disability assistance, or to report a discrimination complaint, please, call **1-800-468-9698** for BlueCare, **1-888-325-8386** for CoverKids or **1-800-263-5479** for 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](http://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

<b>Commercial Service Lines</b>	800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. ET	
<b>Commercial UM</b>	800-924-7141
Monday-Thursday, 8 a.m. to 6 p.m. ET Friday, 9 a.m. to 6 p.m. ET	
<b>Federal Employee Program</b>	800-572-1003
Monday-Friday, 8 a.m. to 6 p.m. ET	
<b>BlueCare</b>	800-468-9736
<b>TennCareSelect</b>	800-276-1978
<b>CoverKids</b>	800-924-7141
<b>CHOICES</b>	888-747-8955
<b>ECF CHOICES</b>	888-747-8955
Monday-Friday, 8 a.m. to 6 p.m. ET	
<b>BlueCare Plus<sup>SM</sup></b>	800-299-1407
Seven days/week, 8 a.m. to 6 p.m. ET	
<b>Select Community</b>	800-292-8196
Monday-Friday, 8 a.m. to 6 p.m. ET	
<b>BlueCard</b>	
Benefits & Eligibility	800-676-2583
All other inquiries	800-705-0391
Monday-Friday, 8 a.m. to 6 p.m. ET	
<b>BlueAdvantage</b>	800-924-7141
Seven days/week, 8 a.m. to 9 p.m. ET	
<b>eBusiness Technical Support</b>	
Phone: Select Option 2 at	423-535-5717
Email:	<a href="mailto:eBusiness_service@bcbst.com">eBusiness_service@bcbst.com</a>
Monday-Friday, 8 a.m. to 6 p.m. ET	