

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.



Keep Your Information Current

Please make sure your information is accurate in your CAQH account. Keeping this information current helps make sure that we deliver all communications to you successfully.

INSIDE THIS ISSUE

BlueCross BlueShield of Tennessee, Inc.

- [Keep Your Information Current](#)
- [Spravato® Billing and Documentation Basics](#)
- [Updates to the Durable Medical Equipment Network](#)
- [Member ID Card Changes Coming for All Blue Plans by 2028](#)
- [Change of Ownership Reminder](#)
- [Stay Informed by Submitting Prior Authorizations in Availity](#)
- [A Faster Way to Receive Important Communications From Us](#)
- [New Inquiries, Reconsiderations and Appeals Tool in Availity](#)
- [View Our 2026 Healthy Tennessee Report](#)
- [About the Provider Exclusion Screening Process](#)

Commercial

- [Understanding the Behavioral Health \(BH\) Comprehensive Network](#)
- [Future Updates: See the Latest and What Changes Are on the Way](#)

BlueCare Tennessee

- [Talk About Preeclampsia With Your Pregnant Patients](#)
- [Caring for Children's Mental Health](#)
- [Save the Date for Our June 2026 EPSDT Virtual Workshop](#)
- [Availity Supports More Efficient Care for Children in DCS Custody](#)
- [Billing Leave of Absence Codes](#)
- [Non-Emergency Medical Transportation Reminders](#)
- [Coming Soon: Program Integrity Audit Medical Record Request](#)
- [Submitting Claims vs. Reconsiderations in Availity](#)

BlueCare Plus Tennessee

- [CMS Releases Updated Medicare Outpatient Observation Notice \(MOON\)](#)
- [Provider Star Ratings Now Available in Availity](#)
- [Complete the 2026 Special Needs Plan Model of Care \(MOC\) Training](#)

BlueCare Plus Tennessee and Medicare Advantage

- [New Post-Acute Care Partnership with tango and WellSky®](#)

Quality Corner

- [Osteoporosis Care for Women](#)
- [Follow-Up After High-Intensity Care for Substance Use Disorder \(FUI\)](#)
- [THCII Episodes of Care Quarterly Report Release](#)

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](#)

Spravato® Billing and Documentation Basics

If your claim is audited:

- Send the Spravato REMS Monitoring Form.
- Include notes that show why the drug was needed and how it was given and monitored.
- If billed with **G2082/G2083**, include the invoice from the specialty distributor.

These G codes can only be used when the drug comes from a specialty distributor.

What to document:

- Names and roles of all staff who gave or monitored Spravato.
- Who did the monitoring (clinical staff or physician/QHP).
- Total face time for each person.
- Keep staff time (**99415/99416**) separate from physician/QHP time (**99417** or **G2212**).

Updates to the Durable Medical Equipment Network

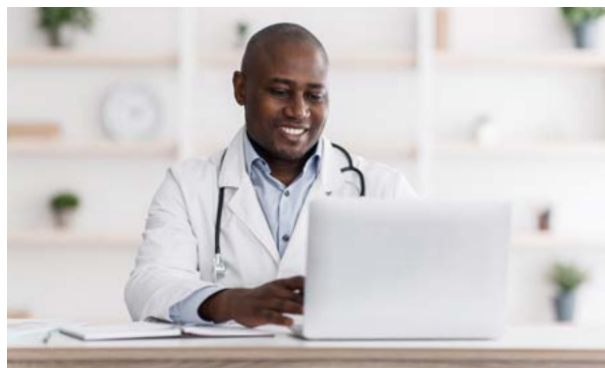
As of **March 6, 2026**, we've contracted with CareCentrix to manage our durable medical equipment (DME) network. This change supports our broader efforts to address rising health care costs while maintaining members' access to the DME services and products you currently order for your patients.

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

Member ID Card Changes Coming for All Blue Plans by 2028

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

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



Choosing the right prolonged services code:

- **Clinical staff monitoring:** Use **99415/99416** when time limits are met.
- **Physician/QHP monitoring:** Bill the visit plus **99417** for extra time.
- **Medicare Advantage/DSNP:** Use **G2212** for physician/QHP time only.

Refer to the CPT® Codebook and applicable CMS guidance for detailed reporting requirements.

For DME requiring prior authorization, providers should continue following the current BlueCross prior authorization process through Avality. 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 2026**. After that, CareCentrix will begin reviewing and approving prior authorization requests for all networks.

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

We're still in the planning phase, but you may start seeing updated cards from members with other Blue plans or BlueCard benefits soon. Continue to check BlueAlert for updates.

Change of Ownership Reminder

If you're acquiring or being acquired by a provider facility or group, you must give us at least 60 days advance 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](#).

Stay Informed by Submitting Prior Authorizations in Availity

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

When you submit a prior authorization in Availity:

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

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



A Faster Way to Receive Important Communications From Us

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

You can update your contact preferences by following these steps in Availity. Simply select email instead of mail for all types of communication and add a contact name and email address for each one.

Follow these steps in Availity:

1. Log in to **BlueCross Payer Spaces**.
2. Select the **Contact Preferences & Communication Viewer** tile.
3. Choose your **Contact Type**.
4. Select your **Organization** and **Tax ID**. (Tax ID is a newly added feature that lets you select a specific provider based on Tax ID. You can update contact information for all Tax IDs, including the primary Tax ID associated with the corresponding NPI.)
5. Pick a provider from the drop-down list or manually enter the provider's **NPI** and click **Submit**.
6. Follow the remaining cues and check the email **Opt In** box. Make sure email is the first option in the **Communication Preference** list on the right side. When finished, click **Save & Submit**. You can apply the same updates to other contact types by checking **Contact Type** boxes – or the **Select All** box, which automatically checks all contact types you have access to. In some cases, you may find it takes time to receive these messages through your newly specified email, and you may temporarily receive them as you did before.

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

A **Contact Preference Quick Reference Guide** is available under the **Payer Spaces Resources** tab in Availity. If you have questions, please log in to Availity or contact eBusiness Technical Support at **(423) 535-5717, option 2**.



New Inquiries, Reconsiderations and Appeals Tool in Availity

Our new online inquiries, reconsiderations and appeals tool is now available in Availity. Previously, we accepted these submissions by phone, fax, mail and email. But as of **April 1, 2026**, all providers are required to submit inquiries, reconsiderations and appeals through our claims dispute tool in Availity. We're no longer accepting these submissions by fax, mail or email.

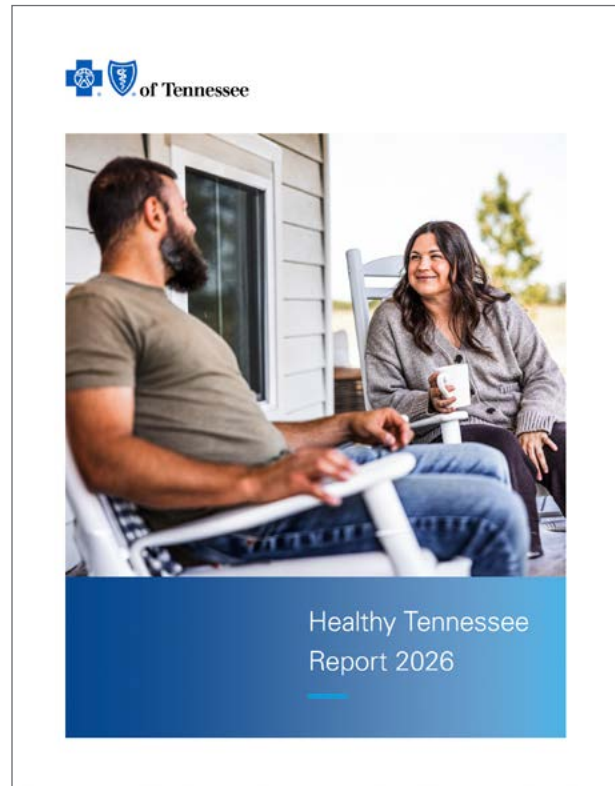
For more information, please keep an eye out for additional resources in our Payer Spaces in Availity or contact your **eBusiness Network Manager**.

View Our 2026 Healthy Tennessee Report

We want every Tennessean to have the opportunity to pursue their health goals. This is a purpose we share with our provider community. You're the front line of prevention, early detection and chronic disease management for our members. We're here to support you by providing actionable information about our members and their health needs.

We recently published our third annual **Healthy Tennessee Report**. It provides demographic information and details about key social risk factors affecting our members. The report also tracks 20 of the top health metrics for Tennesseans enrolled in our Medicaid and Commercial plans to help identify how social risk factors, backgrounds and geography correlate with health disparities. We encourage you to review it.

Clinical care is more effective when social needs are addressed. By understanding and addressing barriers to care, we can better work together to improve the lives of the people we serve.



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, System for Award Management, and the Tennessee Terminated Providers List.

The screenings should be conducted prior to hiring employees or contracting with individuals and entities, and every month following. 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**.

Commercial

This information applies to Blue Network PSM, Blue Network SSM, Blue Network LSM and Blue Network ESM unless specifically identified below.

Understanding the Behavioral Health (BH) Comprehensive Network

Medical providers are typically contracted for specific Commercial networks. Depending on the region, a provider may be part of one or several of these networks.

BH providers are contracted into the BH Comprehensive Network, which automatically includes all Commercial networks (P, S, L and E). 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 in Network P and the BH Comprehensive Network. However, the provider isn't contracted for Network S.
- In this example, 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 provider and medical provider, because the BH Comprehensive Network covers all networks, and the medical provider is in the member's network.

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



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

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

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

BlueCare Tennessee

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

Talk About Preeclampsia With Your Pregnant Patients

May is Preeclampsia Awareness Month. It's a good time to talk with your expecting patients and their families about preeclampsia. Preeclampsia and other hypertensive disorders affect 5-8% of all pregnancies and can develop quickly. Talking to patients early can better prepare them and improve outcomes if they do develop preeclampsia.

Discuss these topics with your pregnant patients:

- Explain how preeclampsia can cause serious complications during pregnancy and after birth.
- Encourage patients to attend all scheduled prenatal visits to identify blood pressure changes early.
- Review preeclampsia risk factors with patients, including:
 - Medical conditions such as chronic high blood pressure, diabetes, kidney disease and autoimmune conditions – Family history and age
 - Body mass index (BMI)
 - Race and ethnicity
 - In vitro fertilization
- Educate patients about the warning signs of preeclampsia so they can seek care quickly:
 - Swelling in the face, legs or hands
 - Severe or persistent headache
 - Vision changes
 - Sudden weight gain
 - Difficult breathing
 - Nausea and vomiting during the second half of pregnancy
 - Pain in the upper abdomen or shoulder
 - Dizziness

Pregnant and postpartum patients with BlueCare Tennessee coverage can get a no-cost, at-home blood pressure cuff to help monitor their health. Providers can submit an order to an in-network DME provider for their patients to get their at-home cuff.

Caring for Children's Mental Health

May is Mental Health Awareness Month. Children's mental health affects their ability to have a high quality of life. And yearly Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits are a great time to check in on your patients' mental health.

Mental health screenings during EPSDT visits let you check in on your patients' development and emotional health. If you note any areas of concern, you can talk about them with your patients' parent or guardian.

The CDC says the most common mental health conditions for children are anxiety disorders, depressive disorders and behavior disorders. These conditions are often long-term, but treatment can help your patients better manage their mental health.

You can find more information about EPSDT visits and starting conversations with parents and guardians in our [EPSDT Partners In Prevention booklet](#).

Save the Date for Our June 2026 EPSDT Virtual Workshop

We're hosting our first EPSDT virtual provider workshop of 2026 on **June 11** from **noon-1:30 p.m. ET**. Please plan to join us. We'll share more event and registration details soon.

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

Availity Supports More Efficient Care for Children in DCS Custody

Children in Department of Children's Services (DCS) custody and those receiving Supplemental Security Income often experience frequent transitions, complex care needs and multiple care coordinators. Availity helps providers manage this complexity by giving practices one streamlined platform to complete essential administrative tasks quickly and accurately.

Key advantages for providers include:

- **Real time eligibility and benefits** — You can confirm coverage, copays, deductibles and authorization needs instantly, which is especially important when a child's placement or caregiver changes.
- **Cleaner, faster claims** — Standardized workflows reduce denials and speed up reimbursement for services these children rely on.
- **One portal for multiple payers** — Staff avoid switching between systems, reducing errors and saving time.
- **Lower administrative burden** — Fewer manual steps free up time for care coordination with caseworkers, caregivers and specialists.
- **Stronger communication with payers** — Shared, accurate information supports quicker issue resolution and helps maintain continuity of care.

Efficient administrative processes help prevent gaps in care, reduce delays in treatment and support more stable health outcomes for children who already face significant challenges.

Billing Leave of Absence Codes

Revenue code 0180 and occurrence code 74 (leave of absence) aren't appropriate for acute care facility billing. These codes are specific to skilled nursing facilities and shouldn't be reported on acute care facility claims.

Non-Emergency Medical Transportation Reminders

BlueCare and TennCare*Select* members get non-emergency medical transportation to and from health care appointments as part of their benefits. Members should book rides and get any needed prior authorization at least two business days before their trip. Your patients can find information about scheduling trips in their Member Handbook and on [our website](#).

Requesting trips to medical services in Tennessee

Your patients should contact Verida, Inc. directly to schedule transportation. They can call the number below for their plan 24/7 or schedule online at [member.verida.com](#).

BlueCare members call **1-855-735-4660**.

TennCare*Select* members call **1-866-473-7565**.

Out-of-state trips or trips for minors riding alone

If your patient needs to travel out of state or if a minor is traveling alone, please ask them or their representative to call us. BlueCare members call **1-800-468-9698**. TennCare*Select* members call **1-800-263-5479**. TTY users call **711** and ask for **888-418-0008**.

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

Coming Soon: Program Integrity Audit Medical Record Request

BlueCare Tennessee is currently undergoing a Managed Care Plan Program Integrity Audit. As part of this audit, our network providers may get a request to submit medical records.

SafeGuard Services LLC is conducting this audit on behalf of CMS. If you're included in the sample set of providers chosen to submit medical records, please send the records to SafeGuard Services LLC (not BlueCare Tennessee) by the due date. Selected providers will receive more information about SafeGuard Services LLC and instructions for returning their medical records.

We appreciate your prompt response and help with this request.



Submitting Claims vs. Reconsiderations in Availity

Choosing the correct submission type helps avoid delays and ensures faster payment.

Claims Denied for an EOB or MSN

If a claim denied because an Explanation of Benefits (EOB) or Medicare Summary Notice (MSN) was missing, a reconsideration isn't required.

What to do:

- Submit the claim as a new claim (not corrected).
- Attach the required EOB or MSN.

This process is more efficient and results in quicker payment than submitting a reconsideration.

If you're concerned about duplicate denials, automation is in place to recognize the attached EOB/MSN so the claim isn't processed as a duplicate.

Reminder: If you're only submitting missing documentation (such as an EOB or MSN), resubmit the claim with the attachment instead of submitting a reconsideration.

When to Submit a Reconsideration for BlueCare Tennessee

Reconsiderations may be submitted for claims denied due to:

- Timely filing
- Contract reimbursement
- Medicaid ID or disclosure issues
- Post payment audits
- Third party liability
- Code bundling or editing
- PCP denials

If your denial falls into one of these categories, submitting a reconsideration through Availity is appropriate.

BlueCare Plus Tennessee

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

CMS Releases Updated Medicare Outpatient Observation Notice (MOON)

The Office of Management and Budget has approved the CMS-updated Medicare Outpatient Observation Notice (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 (CAH).

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



Provider Star Ratings Now Available in Availity

The final 2025 Star ratings for the BlueCare Plus Tennessee Quality+ Partnership Program are now available in Availity. Participating providers can see their 2025 Star rating by logging in to Availity and going to the Quality Care Rewards application. Then click the **Scorecards** tile and choose the **Prior Year Scorecards** link under the **More Information** tile. You can find your rating at the top of the scorecard.

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

Providers participating in BlueCare Plus Tennessee special needs plans are contractually required to complete our MOC training after initial contracting, then every year afterward. This training promotes quality of care and cost effectiveness through coordinated care for our members with complex, chronic or catastrophic health care needs. You can access the online self-study training and attestation by [clicking here](#).

BlueCare Plus Tennessee and Medicare Advantage

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

New Post-Acute Care Partnership with tango and WellSky®

As of **April 27, 2026**, we're working with **tango** and **WellSky** to manage skilled home health and post-acute facility services for Medicare and Medicaid dual-eligible special needs plans.

tango

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

WellSky

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

tango and WellSky will help us manage:

- Referral coordination
- Prior authorization and continued stay reviews
- Transition of care support

To learn more about tango and home health authorization:

- May 5 | 10 a.m. ET (9 a.m. CT) – [Webinar Link](#)
- May 7 | 10 a.m. ET (9 a.m. CT) – [Webinar Link](#)

To learn more about WellSky and inpatient rehab, long-term acute care and skilled nursing authorization:

- May 5 | 2 p.m. ET (1 p.m. CT) – [Webinar Link](#)
- May 7 | 2 p.m. ET (1 p.m. CT) – [Webinar Link](#)

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

- Phone – **1-888-258-3864**
- Web – providerresourcecenter.com/bcbstn

Quality Corner

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

Osteoporosis Care for Women

Osteoporosis Management in Women (OMW) is a measure that checks whether women ages 67-85 get the right bone care after they break a bone.

Patients must receive **one** of the following within 180 days of a fracture:

- Bone Density Test
 - After a fracture or within the past two years
- Osteoporosis Medication
 - Must be filled at a pharmacy through Medicare Part D

Important: Calcium, vitamin D, exercise advice or fall prevention tips **don't** count on their own.

Good notes help close the care gap. Be sure to:

- Record the fracture date and location
- Document bone test orders or results, or why a bone test wasn't done
- Take note of the medication prescribed, if the patient refused treatment, and any medical reasons why treatment wasn't started
- Include a follow-up plan

Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)

Timely follow-up after intensive Substance Use Disorder treatment is essential for improving treatment completion, supporting ongoing recovery and lowering long-term health and societal costs.

The Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) HEDIS® measure evaluates how effectively patients ages 13 and older receive follow-up care after inpatient, residential or withdrawal management treatment. The measure includes two rates: a seven-day follow-up and a 30-day follow-up after discharge, each requiring a qualifying visit with an SUD diagnosis.

Strategies to meet this measure include:

- Scheduling the follow-up appointment before discharge
- Following up within three to five days (or 72 hours for high-risk patients)
- Using multiple qualifying visit types such as in-person, telehealth, or certain telephonic services.
- Connecting patients with outpatient providers before discharge
- Addressing barriers such as transportation, phone access, housing stability, medication coverage, and safety concerns
- Reminders via phone calls or texts
- Immediate outreach after missed appointments
- Accurate documentation using qualifying diagnosis and procedure codes ensure proper measure capture.

Coordinating with care management teams and community providers, sharing discharge summaries promptly and maintaining daily tracking of upcoming discharges all support timely follow-up scheduling. Educating patients on the purpose of follow-up care further increases their engagement and follow-through.

Sources

- iowatotalcare.com
- ncqa.org
- drugabusestatistics.org

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



THCII Episodes of Care Quarterly Report Release

New quarterly reports for BlueCare Episodes of Care Quarterbacks will be available **May 21, 2026**. If you're having trouble accessing your quarterly report, please call **(423) 535-5717** and press option 2 or email eBusiness_Service@bcbst.com.

Pharmacy

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

Step Therapy for Additional Medicare Part B Drugs

Effective **May 1, 2026**, BlueAdvantage and BlueCare Plus are implementing step therapy for additional Part B drugs. This only affects members who are new to therapy. Prior authorization and step therapy are in line with CMS regulations and required for the following Part B drugs:

- Enoby™
- Xtrenbo
- EXDENSUR
- RITUXAN® for pemphigus vulgaris
- EYDENZELT®
- ULTOMIRIS® for NMOSD
- HYMOVIS® ONE
- UPLIZNA® for gMG
- QIVIGY®



The following Part B drugs no longer require step therapy, but will continue to require prior authorization:

- SELARSDI™
- YESINTEK

You can find our Part B Step Therapy guide on [provider.bcbst.com](#). Go to **Documents and Forms** and click the **Part B Step Therapy Provider Reference Guide**. You can also find a link directly to the document [here](#).

Please reach out to us if you have any questions.

Mid-Year Preferred Formulary Changes Effective July 1

Effective **July 1, 2026**, we'll be making a few changes to the Preferred Formulary. These changes include:

- 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](#). 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 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)	