

Format for Submission of Mental Health Rates

	A	B	C
1	FIELD NAME	PICTURE	COMMENTS
2	Provider/Facility Number	X(9)	Employer Identification Number (EIN)
3	Fiscal Year	9(2)	Current Fiscal Year plus the two previous Fiscal Year Iterations
4	Facility Type	9(1)	1=Inpatient 2=Half Day Partial 3=Full Day Partial 4=RTC
5	Facility Name	X(40)	Name of the Facility Providing the Treatment
6	Facility Street Address	X(30)	Street Address of the Facility
7	Facility City	X(18)	City Where the Facility is Located
8	Facility State or Country Code	X(2)	State or Country Where Facility is Located (Alpha Code) (TRICARE Systems Manual (TSM), Chapter 2)
9	Facility Zip Code	X(9)	Zip Code Where Facility is Located
10	Per Diem Rate (Separate Record for each Per Diem Rate)	9(7)v99	1=Inpatient High Volume Per Diem Rate 2=Inpatient Low Volume Per Diem Rate - Adjusted by Wage Index and IDME Factors 3=Half Day Partial Hospitalization Per Diem Rate 4=Full Day Partial Hospitalization Per Diem Rate 5=RTC Per Diem Rate
11	High Volume Indicator	X(1)	Indicates if Facility is High Volume (1=True, 0=False)
12	High Volume Date	9(8)	If High Volume Indicator is True - Date Facility Became High Volume YYYYMMDD
13	High Volume Per Diem or RTC at Cap Amount	9(7)v99	If Per Diem has been Limited by Cap Amount, Provide Capped Amount