

**Home Health Visits
WyNETTE Project
Bill One Type of Visit Only**

Please Complete this part for Contact or No-Contact Visit:

Home Health Agency _____

Nurse Name _____

Client Name _____

Client ID # _____

Date of Service _____

Choose Below Which Type of Visit Was Made

**Contact Visit Billing
Revenue Code 562 & Code S9445**

Visit with Client Occurred:

Circle one: Yes _____ No _____

**No-Contact Visit
Mileage Verification Billing
Revenue Code 562 & Code A0160
Travel Information**

Begin City _____ Destination Location _____
(Street Address & City)

Total Miles _____ X 2 (round trip) = _____
(Total Distance from Begin City to Destination) (Mileage)

Reimbursable Amount = _____ X \$0.48/ Mile = \$ _____
(Reimbursable Miles)