Donor Human Milk Request Form

Donor Human Milk Request Form
(Must be Reordered Every 180 Days)

Client Name:	Client Medicaid Number:
Date of birth:	Client's weight:

Include this Donor Human Milk Request Form with the Prior Authorization Request Form. Parts A and B of this form must be completed and copies retained in both the physician's and the milk bank's records. These forms and clinical records are subject to retrospective review.

Part A

The physician must keep up-to-date documentation of medical necessity and the signed written consent form in the child's clinical record to be considered for Medicaid reimbursement.

☐ The medical necessity for breast milk* is:

Child's diagnosis:

Date of last feeding trial: / /

Reason donor milk is the only appropriate source of human milk for this client:

*This information must be supported by written documentation in the clinical record of why this infant cannot survive and gain weight on any appropriate formula, such as an elemental formula or enteral nutritional product, other than donor human breast milk, and that a clinical feeding trial of an appropriate, nutritional product has been considered with each authorization.

☐ The parent/guardian has signed and dated an informed consent that the risks and benefits of using banked donor human milk has been discussed with them.

Dates of service requested	From:	To:	Quantity Requested:
Physician's Signature:		Date: / /	
Physician Name:		Physician's Fax Number:	
License Number:	TPI:	NPI:	

Part B

The particular donor human milk bank adheres to quality guidelines consistent with the Human Milk Banking Association of North America, or other standards established by the Division of Medicaid and Health Financing.

Yes ☐ No ☐

Milk Bank Name:	Milk Bank Fax Number:	
Milk Bank Address:		
Milk Bank Representative Signature	Date: / /	
Milk Bank Representative's Name:	TPI:	
NPI:	Taxonomy:	Benefit Code: