GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Donor Human Milk Request Form		
Infant Name:	Infant (or Mother) Medicaid Number:	
Date of Birth:	Infant Weight:	
Parts A and B of the Donor Human Milk Request Form must be completed and copies retained in both the physician's and the providing milk bank's records. These forms and clinical records are subject to retrospective review by DHCF or its designee.		
Part A		
Explanation of medical necessity for breast milk[1] :		
Child's diagnosis:	Date of last feeding trial[2]:	
Reason human donor milk is only appropriate source to correct or ameliorate condition or defect:		
□ The parent/guardian has signed and dated an informed consent that details the risks and benefits of using banked donated human milk.		
Quantity Requested (cc/day **or** oz/month):	Dates of Service Requested: *From* *To*	
Physician Name:		
Physician's Phone:	Physician's Fax:	
License Number:	DC Provider #:	NPI:
Physician's signature:		Date:
Part B (To be completed by donor milk bank)		
Milk Bank Name:		
Milk Bank Phone:	Milk Bank Fax:	
Milk Bank Address:		
DC Provider #:	NPI:	Taxonomy:
Quantity of Milk Provided (cc **or** oz):	Dates covered by quantity provided: *From* *To*	
Milk Bank Representative Name and Signature:		Date:

[1]Information provided *must* be substantiated by written documentation in the infant's clinical record maintained by the treating physician. The documentation must include why the particular infant cannot survive and grow as expected on any other formula (e.g., elemental, special, or routine formulas or food) or any enteral nutritional product other than donor human milk.

[2] A clinical feeding trial must occur every 180 days. If infant is too fragile for a feeding trail, documentation must be provided supporting that the illness makes the infant too fragile to test.