STATEMENT OF MEDICAL NECESSITY
FOR PASTEURIZED DONOR HUMAN MILK

15875 SW 74th Ave, Tigard, OR 97224 • Phone: 503-469-0955 • Fax: 503-469-0962 • donatemilk.org
Hours: Mon-Thu 8:30 am - 4:30 pm, Fri 9 am - 3 pm

northwest MOTHERS MILK BANK

***** ONLY REQUIRED IF INFANT IS MORE THAN 6 MONTHS OLD *****

Infant Name(s) _____ Infant DOB _____

Parent/Guardian Name(s) _____

Insurance Provider _____

Member ID _____ Group Number _____

To whom it may concern:

I am requesting human donor milk for my patient due to a medical diagnosis. Donor breastmilk (HCPCS T2101) from an accredited human milk bank is recommended when a mother's own milk is not 100% available. Donor milk is a limited resource and is necessary for the health of fragile infants. Please find the diagnoses below and the prescriptions and relevant chart notes (if requested) attached.

Check all that apply	Diagnosis	ICD-10 Code	Check all that apply	Diagnosis	ICD-10 Code
	Premature Newborn (<37 weeks gestation)	P07.3		Congenital Anomaly of the Digestive System	Q45.9
	Feeding Problem, Newborn (if <28 days of age)	P92.9		Congenital Diaphragmatic Hernia	Q79.0
	Hx of Necrotizing Enterocolitis (NEC)	K55.30		Gastro-esophageal Reflux	K21.9
	Abnormal Weight Loss	R63.4		Prune Belly Syndrome	Q79.4
	Low Birth Weight, less than 500gm	P07.01		Intestinal Malabsorption	K90.9
	Low Birth Weight, less than 500gm - 749gm	P07.02		Failure to Thrive	R62.51
	Low Birth Weight, less than 750 gm - 999gm	P07.03		Congenital Renal Disease	P96.0
	Low Birth Weight, less than 1000gm - 1249gm	P07.14		Combined Immunodeficiencies (SCID)	D81.9
	Low Birth Weight, less than 1250gm - 1499gm	P07.15		Bronchopulmonary dysplasia	P27.1
	Low Birth Weight, less than 1500gm - 1749gm	P07.16		Awaiting Organ Transplantation	Z76.82
	Low Birth Weight, less than 1750gm - 1999gm	P07.17		Neonatal withdrawal symptoms from maternal use of drugs of addiction	P96.1
	Low Birth Weight, less than 2000gm - 2499gm	P07.18		Other:	

PROVIDER INFORMATION

I certify that the above nutritional therapy is medically necessary, and that the information provided is accurate to the best of my knowledge. I also acknowledge that I have obtained the legal guardian's authorization to release medical information for this infant. Approval for this request for the milk bank and possible insurance coverage and reimbursement will make a significant impact on the health of this infant.

Provider Name _____ Physician NPI # _____

Provider Email _____ Provider Phone _____

Clinic or Hospital Address _____

City _____ State _____ Zip _____

Physician Signature _____ **Date** _____

***** PLEASE FAX TO 503-469-0962 *****