



ABOUT

The Outpatient Program at Mothers' Milk Bank Southeast focuses on serving infants who have complex medical needs, as well as supporting families with short-term supplementation as maternal milk production becomes established. We can expand our care to additional infants as donation volumes continue to grow. For more information about current availability, please contact us.

PROCESS

If you have a patient with a medical need for pasteurized donor human milk (PDHM), please complete the following information provided on this form.

You may fax the completed form to 615-285-8238 or provide a copy of the form to the infant's parent or guardian to submit to us.

Additionally, all parents or guardians must complete our Outpatient Form at mymilkbank.org/outpatient which includes a parental consent form.

PROCESSING FEES

The processing fee is \$14.95 per 100 mL bottle. The processing fee covers a portion of the significant costs of donor screening, nutritional analysis, pasteurization, microbiological testing, and storage. Financial assistance for up to 40 bottles is available through the Rosie Fund for qualifying households. Please visit mymilkbank.org/outpatient for more information.

INSURANCE COVERAGE

Insurance coverage for Pasteurized Donor Human Milk (PDHM) remains limited and varies by insurance plan, medical diagnosis, and location. In Tennessee and throughout much of the Southeast, families may find that donor human milk is not a covered benefit or that coverage is subject to specific medical criteria, authorization requirements, or other limitations.

Mothers' Milk Bank Southeast does not bill or file claims with commercial insurance plans. If you wish to seek reimbursement, we can provide an itemized receipt for you to submit to your insurance provider. Because coverage policies differ, we encourage families to contact their insurance company directly to ask whether Pasteurized Donor Human Milk is covered for their infant and what documentation may be required.



OUTPATIENT PRESCRIPTION FORM

PATIENT INFORMATION

Infant's Name: _____ Date of Birth: _____

Parent/ Guardian Name(s): _____

Phone: _____ Email: _____

Address: _____

MEDICAL NEED FOR DONOR MILK

Prescribed Volume (per day): _____ Length of Time: _____

Diagnosis*: _____ ICD-10 Code: _____

Additional Information: _____

***Formula intolerance refers to inadequate growth or ongoing symptoms following three or more documented trials with breastmilk substitutes, including amino acid-based or hypoallergenic options.**

PROVIDER'S INFORMATION

Prescribing Physician: _____ NPI #: _____

Clinic/Hospital: _____ Phone: _____

Address: _____

Physician's Signature: _____ Date: _____

PDHM orders are not final or guaranteed until the family contacts Mothers' Milk Bank Southeast to confirm the availability and finalize order details.