LACTATION CENTER & MOTHER'S MILK BANK
3000 New Bern Avenue
Raleigh, NC 27610
919 350-8599
Fax 919 350-8923

DONOR MILK PROGRAM FACT SHEET

Thank you for your recent inquiry and interest in our Donor Milk Program. Please read this information carefully and contact our office at (919)-350-8599 with any questions.

- The current price of donor milk is $4.50 per ounce, including shipping and handling. If you pick up the donor milk from the Milk Bank the price is $3.50 per ounce. Prices are subject to change at any time.
- Donor milk is a sterile supply and cannot be returned for credit after shipment.

Participation in the program falls into one of two categories, (1) medical necessity or (2) elective. Both categories require a physician's order or prescription indicating the diagnosis to participate.

- Medical Necessity

WakeMed will file insurance (including Medicaid) for medically necessary donor milk. The insured or account guarantor is responsible for obtaining any pre-approval or authorization from their insurance carrier. If insurance denies the claim, the entire balance becomes patient responsibility.

- Elective

WakeMed will not file insurance (including Medicaid) for patient's recieveing donor milk on an elective basis. The entire balance is patient responsibility.

Payment Options
WakeMed has several options for making ayment on self-pay balances. We offer a prompt payment incentive of 30% to customers who pay by credit card within 7 days of a billing notice being issued. To take advantage of this option, enter your credit card information on the account set-up sgeet enclosed with this packet. If you are unable to take advantage of this option, payment in full is expected within 30 days of the account reaching a self-pay status, unless approved for an installment plan or financial assistance. A financial statement and supporting documents are required to be reviewed for financial assiatance. Our installment terms are below:

Amount Due	Monthly Terms
$100 or Less	Payment in Full
$101-$500	3 Months
$501-$1,000	6 Months
$1,001-$5,000	12 Months
$5,001-$10,000	24 Months
$10,001 or Greater	36 Months

You may pay by check, MasterCard, Visa, Discover, Debit Cards, and monthly draft.

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WakeMed Donor Milk Program Agreement

Date: ____________________

Guarantor: ____

Address 1: ____

City: ______________________ State: ______________ Zip: ______________

Recipient Name: ____

Dear Mr/Ms:

To begin your participation in the program please read the Donor Milk Program fact sheet. Keep this for your records.

A prescription from the recipient's doctor is needed. This must be received by the Mother's Milk Bank prior to milk being dispensed. The prescription should include the number of ounces per day and the number of days. It should include several refills as well. This can be faxed, mailed, or emailed to suevans@wakemed.org.

Please complete this form along with following attached forms:

1. Patient Registration form
   a. The diagnosis should be as detailed as possible. If there is more than one diagnosis, please list them. If the recipient is a premature baby, please give the weeks gestation and list any other complications that may help with an insurance claim.
   b. Provide a copy of any applicable insurance card.

2. Agreement for Use of Donor Milk form

3. WakeMed Consent/Authorization form

You may fax this information to us at (919) 350-8923, email us at the above email address, or send it by mail using the address below:

ATTN: Sue Evans, RN, IBCLC
WakeMed Donor Milk Program
3000 New Bern Avenue
Raleigh, NC 27610

Please note that milk cannot be dispensed until all of the required documents have been received.

If you have additional questions regarding participation, or pricing, please contact the **Mother's Milk Bank at (919) 350-8599**. Questions regarding payment arrangements should be directed to **Patient Financial Services Customer Service at (919) 350-8359.**

I acknowledge by my signature below, my understanding of the **WakeMed Donor Milk Program**, and agree to accept financial responsibility for the milk received. I also understand that failure to comply with this agreement could result in the cessation of the donor milk and placement of my account with an outside agency for collection of any balance due.

________________________________ (Signature/seal) ______________ (Date)

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AGREEMENT FOR USE OF DONOR MILK

Human milk is the standard food for infants and young children, including premature and sick newborns, with rare exceptions. Human milk provides optimal nutrition, promotes normal growth and development, and reduces the risk of illness and disease. The unique composition of human milk which includes nutrients, enzymes, growth factors, hormones, and immunologic and anti-inflammatory properties has not been duplicated. When mother's own milk is not available or there is not sufficient volume, pasteurized donor milk from a recognized donor milk bank is the next best option. Pasteurized donor milk retains most of its bioactive properties, which protect the baby from infection while the nutritional components of the milk are the least difficult for the baby to digest.

WakeMed Mother's Milk Bank provides donor milk. The milk bank follows the mandatory guidelines from the Human Milk Banking Association of North America (HMBANA) to ensure the safest product possible is provided. All donors provide milk on a voluntary basis. Only healthy women who are non-smokers and have a healthy lifestyle are accepted as donors. All potential donors are triple screened, including verbal and written screening, contact with both the mother's and baby's healthcare providers, and blood screening. The blood screening for donors includes tests for HIV, HTLV, syphilis and hepatitis. The donor is screened, the milk is pasteurized and then the milk screened for bacterial growth after pasteurization before it is released from the milk bank.

I understand the above information about pasteurized donor human milk.

I, ______________________________ (legal guardian),
(print name)
am in agreement that my baby/child ____________________________ will receive pasteurized donor human milk.

____
Signature

_____/_____/_____
Date

Mother's Milk Bank
Patient Registration

Date: ____________________

Mother's Information	
Mother's Name or Guarantor	SSN
Mailing Address	Home Phone
Shipping Address	
Employer Name & Address	Work Phone

Baby's Information			
Baby's Name (or recipient)			
Birth Date	Race	Sex	SSN
Diagnosis (reason for needing milk)-			

Doctor's Information	
Ordering Physician's Name	Office Telephone
Office Address	

Method of Payment			
Insurance			
Insurance Company	Address		Telephone
Policy Number			Group Number
Subscriber Name			Date of Birth
Medicaid			
Medicaid Name on Card		Medicaid Number	State
Self-Pay			
Credit Card	Visa	MasterCard	Other
Name on Card	Credit Card Number	Security Number	Expiration Date

Revised by: April Murphy
Date: 5-5-2009

WakeMed Consent/Authorization

Authorization For Diagnosis and Treatment
I, having a condition requiring health care, hereby consent to the provision of such care, which may include routine diagnostic procedures and such treatment as the attending physician(s) or others of the hospital's medical staff consider necessary. I understand that WakeMed is a teaching institution, and I agree that students training to be physicians, nurses, allied health professionals and/or students training in other health related fields may assist in providing my care and that my medical records may be used for purposes of research, education and patient care. I understand that some physicians provide their services as independent contractors to this hospital, and that the hospital is not liable for their acts or omissions.

Medical/Medicaid Patient's Certification: Authorization To Release Information And Payment Request
I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize release of all records by WakeMed required to act on this request. I request that payments of authorized benefits be made on my behalf. This request expires two years from today. I understand I can revoke this authorization at any time prior to that if WakeMed is notified in writing.

Assignment of Insurance Benefits
I hereby authorize payment of hospital benefits, including major medical, directly to WakeMed. I also authorize payment of surgical and/or medical benefits, including major medical, directly to all treating and consulting physician(s) (including WakeMed Faculty Physicians) and vendors, including but not limited to the following independent contractors: Raleigh Pathology Lab Assoc., PA, Critical Health Systems of North Carolina, Wake Radiology Consultants, PA, Wake Emergency Physicians, PA, and other contracted professionals. I understand that I am financially responsible to the hospital and physician(s) providing treatment or consultation, even if such treatment is not covered by insurance.

Authorization For Payment
I do hereby expressly agree to pay and guarantee payment in full of any and all charges for hospital services provided. I understand that my bill will be sent to the address on file unless I complete a request for my bill to be sent to an alternate address.

Authorization For Release of Medical Information
The hospital and licensed physicians providing my care are authorized to release medical information for purposes of treatment, payment and health care operations, including releases to other groups identified under the Assignment of Insurance Benefits section, to emergency transport services, and to entities requiring releases for:

1) processing applications for financial coverage rendered during the admission;
2) external review agencies regarding eligibility for continued hospitalization insurance, payment of benefits, or billing compliance;
3) the acquisition and provision of appropriate care after discharge (including telephone follow-up calls/messages to me/my representative);
4) audits/inspections by agencies of the North Carolina Department of Health and Human Services (DHHS). I understand that I may object in writing to the inspection of my records by the N.C. DHHS and thereby prohibit such inspection.

If I am a pregnant patient of both WakeMed and Wake County Human Services or if my child is a patient of both WakeMed and Wake County Human Services, I authorize each and their physicians to share medical information regarding the acquisition and provision of appropriate care during prenatal care, admission(s) to the hospital, delivery, postpartum care, neonatal and child care and following discharge(s). I also understand and agree that if I request a copy of my record and/or my child's record from either WakeMed or Wake County Human Services that the record may include portions of the medical record from the other entity.

I understand that my name, location and general condition (fair, stable, serious, etc.) will be included in the patient log and will be released, if requested, to callers and/or visitors.

Release of Liability For Valuables
This hospital cannot assume liability for money or valuables taken to the patient's room/treatment area. Money and valuables may be deposited in the hospital safe during your stay.

I understand and agree to the above releases, authorizations and assignments of benefits:

Signature (Seal): ______________________________ Date: __________
(Patient or legal guardian/closest available relative/authorized representative, if patient unable to sign)

Signature (Seal): ______________________________ Date: __________
(Insured/Guarantor, if different from Guardian/Relative/authorized representative)

Consent to Diagnosis and Treatment Obtained By Telephone
Treatment / procedure: ______________________________

Authorized Person Giving Consent: ______________________________

Telephone #: ______________

Relationship to Patient: ______________________________

Witness: ______________________________

Witness: ______________________________

Date: ______________ Time: ______________

PLATE 3/03

Acknowledgement of Receipt of the WakeMed Notice of Privacy Practices
I certify that I have received a copy of the WakeMed Notice of Privacy Practices.

Signature: ______________________________

Print name: ______________________________

Date: ______________________________

____ Signature obtained after initial registration

Staff Use Only:
- ☐ Patient unable to sign due to condition and/or level of consciousness
- ☐ Patient refused to sign after receiving Privacy Notice
- ☐ For ED use only (Privacy Notice given to minor/caretaker in absence of parent)
- ☐ For ED use only (unable to sign due to emergency transfer to another hospital)
- ☐ Other ______________________________

Completed by: ______________________ Date: __________