



3127 Penn Avenue  
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### INPATIENT DONOR MILK USE- PRIVATE PAY FORM

#### Recipient Information

Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female

#### Parent/Guardian Information

Parent(s) or Guardian(s): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

#### Payment Information

Credit Card Type:  Visa  MasterCard  American Express  Discover

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ CVV: \_\_\_\_\_

Name on Card: \_\_\_\_\_

Billing Address (if different than above) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

#### Hospital Information

Facility: \_\_\_\_\_

Number of Bottles Given to Recipient: 100ml bottles \_\_\_\_\_ x \$15.00= \_\_\_\_\_

Bottles will be replaced, free of charge, or cost of bottles will be taken off the hospital's next donor milk order

200ml bottles \_\_\_\_\_ x \$30.00= \_\_\_\_\_

Total to be charged to credit card: \_\_\_\_\_

PLEASE NOTE: Documentation is the same for all recipients. Make sure the patient's chart has:

physician order for donor milk  signed consent form  documentation of bottle(s) batch number(s)

FAX (412-281-4236) or ENCRYPTED EMAIL (orders@midatlanticmilkbank.org) COMPLETED FORM TO THE MILK