State of Alaska • Department of Health and Social Service • Senior and Disabilities Services

Verification of Diagnosis

for

Children with Complex Medical Conditions Program • Older Alaskans Program
Adults with Physical Disabilities Program • Personal Care Services Program

Section 1—to be completed by the care coordinator or personal care services agency representative

Applicant/Participant: _____

Date of birth: _____ Medicaid number: _____

Care Coordinator/Representative: _____

Fax number: _____ Email: _____

Section 2—to be completed by a physician, a physician's assistant, or an advanced nurse practitioner

The diagnostic information requested by this form will assist SDS in determining whether the applicant/participant is eligible for Medicaid services. The ICD-9 code is required for claims processing. Please send the form when completed to the care coordinator or personal care services agency representative at the fax number or email address indicated above.

Primary diagnosis: ICD-9 code _____

Secondary diagnosis: ICD-9 code _____

Additional diagnoses: ICD-9 codes _____

To the best of my knowledge, the above information is true, accurate, and complete.

_____ _____ _____
Physician, PA, or ANP signature Date ID#

_____ _____
Name (*please print*) Telephone number

Questions may be directed to Senior and Disabilities Services at (907) 269-3666 or 1-800-478-9996.