State of Alaska

Department of Health and Social Services
Senior and Disabilities Services
550 West 8th Ave. Anchorage, Alaska 99501
(907) 269-3666 • 1-800-478-9996

Verification of Diagnosis(VOD)

Section I

Applicant/Recipient: _____

Date of Birth: _____ **Medicaid Number:** _____

The information requested will assist SDS to determine if the applicant/recipient qualifies for services. Please complete and return this form to the care coordinator, agency representative or applicant, immediately or at the Fax number or email address indicated.

Care Coordinator or PCA Representative: _____

Phone: _____ Fax: _____ Email: _____

Section II – To be completed by a physician, a physician's assistant, or an advanced nurse practitioner licensed to practice in Alaska

The diagnostic information requested by this form will assist SDS in determining whether the applicant/recipient is eligible for Medicaid services. The ICD-10 Code is required for claims processing.

Both ICD-10 Code and Diagnosis must be provided.

ICD-10 Code: _____ Primary Diagnosis: _____

ICD-10 Code: _____ Secondary Diagnosis: _____

ICD-10 Code: _____ Additional Diagnosis: _____

ICD-10 Code: _____ Additional Diagnosis: _____

ICD-10 Code: _____ Additional Diagnosis: _____

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

Physician, PA, or ANP Signature	Date	License #
Printed Name	Phone #	Fax #

Name of health clinic/
office/organization: _____

Please send the completed form to the care coordinator or agency representative at the fax number or email address noted above. Questions may be directed to Senior and Disabilities Services at (907) 269-3666 or 1-800-478-9996