



**State of Alaska**  
**Department of Health and Social Services**  
**Senior and Disabilities Services**  
**550 West 8<sup>th</sup> 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