State of Alaska • Department of Health• Division of Senior and Disabilities Services

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 requester (the care coordinator or agency representative) as soon as possible, via the Fax number or secure email address indicated below.

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