State of Alaska

Department of Health and Social Services
Senior and Disabilities Services
550 West 8th Ave. Anchorage, AK 99501
(907) 269-3666

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 agency representative, applicant, or SDS Program Manager at the fax number or email address indicated.

Regional Agency or SDS Program Manager: _____

Phone: _____ Fax: _____ Email: _____

Section II – To be completed by a physician, a physician's assistant, an advanced nurse practitioner, registered nurse, speech-language pathologist, occupational therapist, physical therapist, naturopathic physician or neuropsychologist licensed to practice in Alaska

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 regional agency at the fax or email noted above. Questions may be directed to SDS Program Manager via michelle.rogers@hss.soa.directak.net [secure] or (907) 465-4995