



Peer Assistance Services
Start believing.

Provider Verification Form

Date: _____

Client: _____

I, _____, am aware that _____
Provider's Name *Client's Name*

is a client of Peer Assistance Services, Inc. (PAS). He/she has notified me of his/her participation in the program due to his/her illness of _____

Date of Visit: _____

Facility Name: _____

Phone Number: _____

Purpose of visit: _____

Provider's Signature

Date

PAS clients are responsible for submitting this form and copies of all prescriptions to their Case Manager within 24 hours of receipt of prescription. Copies may be submitted by fax: (720)213-1007 or to (970)986-4360 for Western Slope Nursing Clients only.

Mail or Fax Original To:

Metro Denver, Northern and Southern:

Peer Assistance Services, Inc.
2170 S. Parker Road, Suite 229
Denver, CO 80231
Phone: 303.369.0039 or 866.369.0039
Fax: 720.213.1007

Western Slope NURSING Clients Only:

Peer Assistance Services, Inc.
200 Grand Avenue, Suite 260
Grand Junction, CO 81501
Phone: 970.986.4360
Fax: 970.241.9094