



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 (720)213-0002 or to (970)241-9094 for Western Slope Nursing Clients only.

**Mail or Fax Original To:**

**Metro Denver, Northern and Southern:**

**Western Slope NURSING Clients Only:**

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 or 720.213.0002

Peer Assistance Services, Inc.  
200 Grand Avenue, Suite 270  
Grand Junction, CO 81501  
Phone: 970.986.4360  
Fax: 970.241.9094