Provider Verification Form

Date: ______________________________

Pharmacist 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.

Mail or Fax Original To:

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