



Provider Verification Form

Date: _____

Nurse Client: _____

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

is a client of the Nursing Peer Health Assistance Program. 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

Nurse clients are responsible for submitting this form and copies of all prescriptions to the Nursing Peer Health Assistance/Nurse Alternative to Discipline Program within 24 hours of receipt of prescription. Copies may be submitted by fax: (720)213-1007 or to (970)986-4360 for Western Slope 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 Clients Only:
Peer Assistance Services, Inc.
200 Grand Avenue, Suite 260
Grand Junction, CO 81501
Phone: 970.986.4360
Fax: 970.241.9094