



Janssen CarePath Savings Program Patient Assignment of Benefits

1. Please note that this completed form is required in order for the patient's rebate check to be sent to the provider on the patient's behalf for the patient's medication costs.
2. Patients must read the Patient Assignment of Benefits and download, print, and sign.
3. Completed form may be uploaded to Provider Portal (JanssenCarePathPortal.com).

Provider Information

Site Name:

Provider First Name:

Provider Last Name:

Address:

City:

State:

ZIP Code:

Site Phone:

Site Fax:

Patient Information

Patient:

Date of Birth (mm/dd/yyyy):

Patient address:

City:

State:

ZIP Code:

Patient Authorization

My signature on this Patient Assignment of Benefits Form confirms that I authorize each of my Janssen CarePath Savings Program rebate check(s) be sent on my behalf to the provider I have designated on this form for payment of my out-of-pocket Janssen medication cost. I also understand that I may, at any time, call Janssen CarePath and elect for the rebate check(s) to be sent directly to me or for my rebate to be loaded onto a debit card (if available).

Patient Signature: _____

Date: _____

If the patient cannot sign, patient's legally authorized representative must sign below.

By: _____

Date: _____

(Signature of person legally authorized to sign for patient)

Describe relationship to patient and authority to make medical decisions for patient:
