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:

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