Assignment of Benefits

Please sign and return to PANTHERx Specialty by faxing this form to: 855-246-3986
Or mailing this form to:

PANTHERx Specialty Pharmacy
24 Summit Park Drive
Pittsburgh, PA 15275

ACKNOWLEDGMENT OF RECEIPT OF THIS FORM MUST BE SIGNED BY THE PATIENT OR RESPONSIBLE PARTY AND RETURNED TO PANTHERx SPECIALTY, LLC.

I hereby authorize PANTHERx® Specialty Pharmacy to bill my insurance carrier or any other payment source for services furnished by myself or PANTHERx Specialty Pharmacy. I assign all benefits and authorize payment directly to PANTHERx Specialty Pharmacy for any benefits otherwise payable to me for all claims for such services provided or submitted prior to, or after, the date provided on this form.

I authorize any holder of medical or other information about me to release to my insurance carrier and its agents any information needed to determine these benefits or benefits for related services.

I understand that I am financially responsible for payment for all services rendered and that I am obligated to pay all charges denied by my insurance carrier. This assignment and authorization in no way releases me from said responsibility and imposes no obligation on PANTHERx Specialty Pharmacy to collect money on my behalf.

I have read, understand and agree to all the above.

This Assignment of Benefits will be effective until revoked by me in writing. Such revocation shall have a prospective effect only.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

If signed by personal representative (guardian/parent/other legal representative):

Name of Representative: _____

Describe Relationship to Patient: _____