



LIMITATION OF SERVICES REQUEST

Please sign below indicating that you prefer your patients **not** be contacted by AccessOne[®] to receive an explanation of their insurance coverage for Centocor products (see Section IA of the Business Associate Contract).

You acknowledge that your patients may be contacted by AccessOne[®], regardless of your signing this form, in one of two ways:

1. if your patients separately execute the AccessOne[®] patient authorization form; or
2. if your patients contact AccessOne[®] directly.

Centocor, Inc., reserves the right to cancel or modify the AccessOne[®] program at any time.

Please print.

Name of physician or infusion provider _____

Name of practice/facility _____

Address _____

City _____ County _____

State _____ ZIP Code _____

Authorized signature _____ Date _____

Name/title (please print) _____

**Fax completed form to 1-866-489-5955 or mail to
AccessOne[®], P.O. Box 220829, Charlotte, NC 28222-0829**