

NOTE: Your request will not be processed unless you are registered with eKASPER.

To verify your status as a requestor or for assistance with the registration process, please contact the Help Desk by email [to eKASPERHelp@ky.gov](mailto:to_eKASPERHelp@ky.gov) or by phone at 502-564-2703.

To apply for eKASPER access, go to  
<https://ekasper.chfs.ky.gov/accessrequest/accessrequest.aspx>

To be approved for an account, you must complete a two-part process:

1. Fill in the required information on-line.
2. Print out your hard-copy application and sign it along with the Terms of Account Use Agreement. You will have both documents notarized and then mail them, with photocopies of your credentials, to the address provided.

# Request for KASPER Report

Please PRINT or TYPE Information on all lines



<p><b>Patient Name</b>          Name _____  <small>First Last</small></p> <p>Address _____</p> <p>City _____, _____ Zip _____  <small>State</small></p> <p>ID _____          ID Type (check one): <input type="checkbox"/> SSN <input type="checkbox"/> Drivers License</p> <p>DOB _____ / _____ / _____  <small>mm dd yyyy</small></p> <p>Is/was the subject known by other names? <input type="checkbox"/> Other Names *</p> <p>Does/did the subject have other addresses? <input type="checkbox"/> Other Addresses **</p>	<p><b>Date Range for Report</b></p> <p>From _____ / _____ / _____ To _____ / _____ / _____  <small>mm dd yyyy mm dd yyyy</small></p> <p>DEA # _____  <small>Please Print</small></p> <p>Requestor Name _____  <small>Print Name of Prescriber or Pharmacist</small></p> <p>Fax Back Number _____</p>
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\* Other Names (check Other Names box, above)

1. \_\_\_\_\_  
First Last
2. \_\_\_\_\_  
First Last
3. \_\_\_\_\_  
First Last

\*\* Other Addresses (check Other Addresses box, above)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### Requestor Details

Prescriber or Pharmacy Address \_\_\_\_\_

Prescriber or Pharmacy City, State Zip \_\_\_\_\_

Facility or Pharmacy Contact Name \_\_\_\_\_

Prescriber or Pharmacy Telephone # \_\_\_\_\_

I certify that the information will be used for the purpose of providing medical or pharmaceutical treatment to a current or prospective patient.

Requestor's Signature (Prescriber or Pharmacist)

**Limit 15 Requests  
per Fax**

For KASPER Staff Only



**Cabinet for Health and Family Services**  
 Office of Inspector General / Division of Fraud, Waste & Abuse  
 Drug Enforcement and Professional Practices Branch  
 275 East Main Street HS2C-B  
 Frankfort, KY 40621 Phone 502-564-7985  
**Fax 502-696-3880**

