



KASPER Data Submission Registration Form

Facility DEA# _____

Pharmacy/Facility Name _____

Address _____

City _____

State KY _____

Zip Code _____

Contact Name _____

Contact Phone _____ Ext: _____

Contact Email _____

FAX _____

NPI# _____

NABP/NCPDP# _____
Not required if NPI included

Software Vendor or Chain Name _____
If your facility is independent (non-chain), please enter your pharmacy software vendor below (if any). Otherwise, please enter your chain.

Submission Mode
Choose one submission mode

Automatic Network Extract:
RelayHealth will extract the required PMP data from your electronic claims – eliminates manual efforts.

Batch:
Submit ASAP95-formatted batch files via secure Web upload or mailed-in media (CD, DVD, Diskette).

Paper:
Submit paper forms only (requires prior authorization from Kentucky CHFS)

Note: You may only use one submission mode. You may change submission mode later by contacting RelayHealth.

Return completed form to RelayHealth via email
(KYPMP@relayhealth.com) or FAX (404-728-3205)

Questions? Please call 800-892-0333