HICN	Cardholder ID	CMS Contract ID	CMS Plan ID	NDC 11 (no hyphens)	Date of Service	Date of Rejection	Claim Quantity	Claim Days Supply	Patient Residence	Pharmacy Service Type	CMS Part D Defined Qualified Facility	Compound Code	Reject Code 1	Pharmacy Message 1	Reject Code 2	Pharmacy Message 2	Reject Code 3	Pharmacy Message 3	***Sponsor must provide ALL pharmacy messaging, not limited to the number of fields in this template. Please insert columns as necessary.***