TruAssure Grievance Form

Date of Form Submittal

Member/Patient Information

Primary Member Name (policyholder)	Primary Member's Date of Birth (DOB)

Patient Name (if different than policyholder)	Daytime Phone Number	Email Address

Information on Issue to be Addressed

The issues concerns:

☐ Billing ☐ Treatment of Care ☐ Denied Claim(s) ☐ Frequency Limitation ☐ Other _____

Treating Dentist	Dental Office

Office Address	City	State	Zip

Date of Service	Claim number (if applicable)

Is the treating dentist aware of your issue? ☐ Yes ☐ No

If yes, what was their response?

If the dentist is not aware of the issue, why not?

Have you sought a second opinion from another dentist? ☐ Yes ☐ No

If yes, what was the outcome?

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Please describe the nature of your grievance (If you are experiencing pain or discomfort, please include the nature and severity of the pain.)

What is your desired outcome in submitting this grievance?

If an agreeable solution can be reached, would you return to the treating dentist? ☐ Yes ☐ No

Send your grievance to:
Fax #: 630-300-5547, Email: professionalrelations@truassure.com or
Mail to:
TruAssure Insurance Company
111 Shuman Blvd.
Naperville, IL 60563
Attention: Grievance Committee

If you have any questions, please contact us at 888-559-0779.

Please note that if you choose to send this form by email and not fax or mail, communications submitted by email or through the Internet are not considered secure. Although it is unlikely, there is a possibility that information you include in an unsecured email can be intercepted and read by other parties besides the person to whom it is addressed. You always have the option of submitting a grievance by mail or fax. Please do not include any sensitive protected health information, such as your social security number or birth date in email communications you send to us.