



# Provider Directory Feedback Form

**SUBMIT THIS FORM TO TRUASSURE CUSTOMER SERVICE AT  
CSI@TRUASSURE.COM**

**OR**

**MAIL TO MUTUAL OF OMAHA C/O TRUASSURE INSURANCE COMPANY,  
ATTENTION: CUSTOMER SERVICE,  
111 SHUMAN BOULEVARD, NAPERVILLE, IL 60563.**

Please check one or more of the following areas below that are identified as potentially inaccurate or incomplete:

- |  |   |
|--|---|
| <input type="checkbox"/> Provider First, Middle, Last Name | <input type="checkbox"/> NPI number (type I)              |
| <input type="checkbox"/> Suffix                            | <input type="checkbox"/> Gender                           |
| <input type="checkbox"/> Title (DDS or DMD)                | <input type="checkbox"/> Board certification              |
| <input type="checkbox"/> Specialty                         | <input type="checkbox"/> Certifying board                 |
| <input type="checkbox"/> License number and type           | <input type="checkbox"/> Office hours                     |
| <input type="checkbox"/> Office name                       | <input type="checkbox"/> Location languages               |
| <input type="checkbox"/> Address, City, State, Zip         | <input type="checkbox"/> Office email address             |
| <input type="checkbox"/> Phone number                      | <input type="checkbox"/> Providers accepting new patients |
| <input type="checkbox"/> Fax number                        | <input type="checkbox"/> NPI type 2                       |

**PLEASE DESCRIBE ANY POTENTIAL INACCURATE OR INCOMPLETE DIRECTORY INFORMATION:**

## CONTACT INFORMATION:

First Name	Last Name
Phone	Email