



Republika ng Pilipinas
Kagawaran ng Edukasyon
REHIYON V (BIKOL)

TANGGAPANG PANSANGAY NG MGA PAARALAN NG CATANDUANES

15 January 2026

DIVISION MEMORANDUM
NO. 063 s. 2026

SUBMISSION OF THE REPORTIAL REQUIREMENTS FOR MEDICAL ALLOWANCE FY 2025

TO: Assistant Schools Division Superintendent
CID and SGOD Chiefs & Personnel
Elementary and Secondary School Heads
All Others Concerned

1. Pursuant to DepEd Order No. 16 s. 2025, this Office hereby directs all concerned to submit the required reportial requirements for the FY 2024 Medical Allowance **not later than January 30, 2026 (Friday)** to the Administrative Office through the Records Section.

2. All personnel availing through the Individual Availment modes, are required to submit proof of availment or renewal of an HMO-type product or proof of payment for medical expenses. Such proof must bear the name of the concerned DepEd personnel and be accompanied by other supporting documents, subject to the usual accounting, and auditing rules and regulations:

1. In Cash form:
 - a. One (1) copy of Signed Individual Cash Claim Form (Enclosure 1)
 - b. CY 2024 Original Copy of Receipts covering any of the following expenses:
 - I. Consultation Fee
 - II. Laboratory/Diagnostic Tests
 - III. Medication
 - IV. Hospitalization
2. Availed New HMO-type benefit/Payment of Existing or Renewal of HMO-type Benefit:
 - a. Copy of the HMO agreement, or;
 - b. Copy of valid ID issued by the HMO provider, or;
 - c. Official receipt for payment of the membership fee

3. In case where the HMO-type product availed is below the rate of Php7,000.00 medical allowance, the personnel shall not be obliged to refund the excess amount. For the medical allowance used to cover medical expenses, any amount incurred in excess of the Php7,000.00 shall not be subject to reimbursement by DepEd.



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4. Submission shall be arranged in alphabetical order by school/section and accompanied by a transmittal.
5. Personnel under implementing units may submit the required documents through their respective schools.
6. Failure to comply shall result in the withholding of the personnel's medical allowance for the succeeding year until such obligations have been satisfactorily settled.
7. For information, guidance, and strict compliance.

MA. JEANY T. ABAYON

Assistant Schools Division Superintendent
OIC, Schools Division Superintendent



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Enclosure 1 to the DM 063 s. 2026

Annex B
Individual Cash Claim Form

Data Privacy Notice: The Department of Education recognizes its responsibility under the Republic Act No. 10173, otherwise known as the *Data Privacy Act of 2012*, with respect to the data they collect, record, organize, update, use, consolidate, or destruct from their personnel. The personal data obtained from this form is entered and stored within the organization's authorized information and communications system and will only be accessed by authorized personnel. The organization has instituted appropriate technical and physical security measures to ensure the protection of personal data.

Furthermore, the information collected and stored in the portal shall only be used for the purposes of this activity. DepEd shall not disclose any personal information without consent and shall retain this information over a period of ten years for the effective implementation and management of its activities.

Section 1: Employee Information

Full name: _____

Employee ID Number: _____

Position/Designation: _____

Office: _____

Service Duration: (From-To): _____

Sex: _____ Date of Birth (dd/mm/yyyy): _____

Mobile Number: _____

DepEd Email Address: _____

For teaching personnel:

Region: _____

Division: _____

School: _____

Employment Status: Permanent Contractual
 Casual Substitute

Section 2: Pre-requisite Requirements.

Supported with applicable documents, check any of the following condition below that applies.

- GIDA Certification
- Certification of area with no HMO
- Letter or email from HMO denying the application



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Section 3: Details of Medical Expenses Incurred

Name of Medical Provider/Facility	Address	Date(s) of Medical Consultation/Service
(Please add rows as necessary)		

Description of Expense	Amount (in PHP)	Receipt No./Reference
Consultation Fee		
Laboratory/Diagnostic Tests		
Medication		
Hospitalization		
Others (please specify)		
Total Amount		

Please attach original receipts

Section 3: Certification

I, the undersigned, hereby certify that the information provided in this claim form is true and correct to the best of my knowledge, and the medical expenses listed above were incurred for legitimate medical purposes. I understand that submission of false claims shall be subject to disciplinary action and other legal consequences as determined necessary by the Department of Education.

Employee's Signature: _____ **Date:** _____



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