



Republic of the Philippines
Department of Education
CARAGA REGION
SCHOOLS DIVISION OF SIARGAO



Office of the Schools Division Superintendent

September 2, 2025

DIVISION MEMORANDUM

No. **09-269**, 2025

SUBMISSION OF THE REQUIREMENTS FOR THE RELEASE OF MEDICAL ALLOWANCE

To: Assistant Schools Division Superintendent
Functional Division Chiefs
Division Office Personnel
Elementary and Secondary School Heads
All concerned
This Division

1. In view of the implementation of **DepEd Order No. 16, s. 2025**, entitled "Guidelines on the Grant of Medical Allowance to the Department of Education Personnel" and **Memorandum DM-OUHROD-2025-2298**, which mandates the immediate processing and facilitation of the release of the Medical Allowance through payroll disbursement for eligible personnel who have duly submitted Annex A and availed of the Individual Availment Form, all concerned personnel are hereby directed to submit the following reportorial requirements:

a. For Availment of New/Renewal of HMO

- Copy of the HMO Agreement;
- Valid identification (ID) card issued by the HMO provider reflecting the name of the employee; or
- Official receipt for the payment of membership fee for the HMO product acquired.

b. For Payment of Medical Expenses

- Signed Individual Cash Claim Form (Annex B)
- Receipts and any proof of payment of medical expenses such as, but not limited to, hospitalization, emergency care, diagnostic tests, and medicines.
- Certification (their locality/community has no adequate HMO branch or office of a licensed HMO company, as certified by the head of Agency)

2. The aforementioned requirements shall be collected by the AO II and to be checked by the school bookkeeper before it will be submitted to the Division Office (Personnel Unit) by school.
3. Deadline of submission will be on or before **December 1, 2025**.



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4. Failure to comply shall result in the withholding of the personnel's Medical Allowance for the succeeding year, until such obligations are fully settled.
5. Immediate dissemination of and strict compliance with this memorandum are hereby directed.

MANUEL O. CABERTE

Assistant Schools Division Superintendent
Officer-in-Charge
Office of the Schools Division Superintendent

Encl: As stated

Reference: As stated

To be indicated in the Perpetual Index under the following subjects:

MEDICAL ALLOWANCE REQUIREMENTS ELIGIBLE PERSONNEL

OSDS/momosay

09/02/25



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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: _____ Email: _____

For teaching personnel

Region: _____

Division: _____

School: _____

Employment Status: ☐ Permanent ☐ Contractual
 ☐ Casual ☐ Substitute

Section 2: Form of Availment

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

Section 3: Details of Medical Expenses

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



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Description	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: _____