Republic of the Philippines
Department of Education
Region XII
Schools Division Office of Tacurong City

August 12, 2025

DIVISION MEMORANDUM
OSDS No. 110, s. 2025

SUPPORTING DOCUMENTS FOR INDIVUDUAL AVAILMENT AND PAYMENT OF MEDICAL EXPENSES

To: Assistant Schools Division Superintendent
SGOD & CID Chiefs
Division- based personnel
School -based personnel

1. Pursuant to DepEd Order No. 016, s. 2025 re: *Guidelines on the grant of Medical Allowance to the Department of Education*, this aims to ensure access to essential healthcare services for DepEd personnel through the provision of a medical allowance, thereby promoting their overall well-being and enhancing their financial security.

2. The Office issues a uniform guideline on the processing of Medical Allowance.

3. The eligible expenses to utilize the Medical Allowance are the follows:
   a. Payment of Hospitalization
   b. Payment of Emergency Care
   c. Dental Care
   d. Diagnostic tests
   e. Medicines

4. The following supporting documents must be submitted by the concerned personnel:
   a. Annex B: Individual Cash Claim Form (see Enclosure 1)
   b. Cash Invoice/Sales Invoice/Official Receipt from the authorized pharmacy, medical and dental clinic, Hospital and Diagnostic Care.

5. The documents must bear the **NAME OF THE CONCERNED PERSONNEL.**

6. School -based personnel shall submit **three (3)** copies of supporting documents to the school Administrative Officer II while Division – based personnel shall submit to Accounting Section.

7. The School Administrative Officer II shall submit the **three (3)** copies of supporting documents to Accounting Section **on or before December 10, 2025**, following this format:
   - Copy 1 – COA (original documents)

Address: Alunan Highway, Poblacion, Tacurong City 9800
Telephone Numbers: (064)-200-6316; 0919-065-6425
Email: tacurong.city@deped.gov.ph
Website: depedtacurong.org

- Copy 2 – Accounting (photocopies)
- Copy 3 – School (photocopies)

8. Failure to comply the necessary documents mentioned above shall result in the withholding of the personnel's Medical Allowance for the succeeding year, until such obligations are settled.

9. For the information, guidance, and compliance of all concerned.

GILDO G. MOSQUEDA, CEO VI
Schools Division Superintendent

Enclosures: None.
Reference:
Allotment: none
To be included in the perpetual Index under

REPORTS RECORDS

JGS/OSDS/DM/ SUPPORTING DOCUMENTS FOR INDIVUDUAL AVAILMENT AND PAYMENT OF MEDICAL EXPENSES/August 12, 2025

Enclosure 1:

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

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:** _____