



Republic of the Philippines

**Department of Education**  
SCHOOLS DIVISION OF MARINDUQUE

Office of the Schools Division Superintendent

**MEMORANDUM**

OSDS-PS-2026-009

To: Office of the Schools Division Superintendent Officials and Personnel  
School Governance and Operations Division Chief and Personnel  
Curriculum Implementation Division Chief and Personnel  
Public Elementary and Secondary School Heads, Teachers and  
Personnel  
All Others Concerned

From: **LYNN G. MENDOZA, EdD**  
Officer-In-Charge  
Schools Division Superintendent

Subject: **IMPLEMENTATION OF DEPED ORDER NO. 16, S. 2025 (GRANT OF  
MEDICAL ALLOWANCE FOR CY 2026)**

Date: March 6, 2026

1. In reference to DepEd Order No. 16, s. 2025, this Office informs all concerned personnel regarding the implementation of the guidelines on the grant of Medical Allowance for Department of Education personnel.
2. In this regard, all teaching and non-teaching personnel are hereby advised of the following:
  - 2.1 Eligibility. Personnel who are already in the service and are expected to render at least a total or aggregate of six (6) months of service within FY 2026 shall be eligible for the Medical Allowance. Newly hired personnel shall be eligible only after rendering six (6) months of service.
  - 2.2 Personnel who received the Medical Allowance in FY 2025 but have not submitted the required proofs or supporting documents are hereby strongly reminded to comply. Failure to submit the necessary documents may affect their eligibility for the FY 2026 Medical Allowance.
  - 2.3 Qualified personnel may avail of the Medical Allowance in accordance with the provisions and guidelines stipulated in DepEd Order No. 16, s. 2025.
  - 2.4 All eligible personnel shall fill-out the Medical Allowance Registration Form (Annex A) indicating their chosen form of availment. Eligible personnel



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have the option to avail for the following in accordance with the provisions of DepEd Order No. 16, s. 2025 and subject for submission reportorial requirements:

2.4.a Payroll Disbursement for the availment of new/renewal of individual HMO

Proof of enrolment with their HMO provider such as but not limited to any of the following:

- a.1. copy of HMO agreement
- a.2 valid identification card issued by the HMO provider reflecting the name of the employee or
- a.3. official receipt for the payment of the membership fee for the HMO product acquired.

2.4.b Cash form for payment of medical expenses

- b.1. Signed Individual Cash, Claim Form (Annex B) and
- b.2. Certification of GIDA or Certification of No Adequate HMO branch or office, or Proof of Denial from any HMO including but not limited to letter or electronic mail.
- b.3. Original official receipt (OR) dated year 2025 of any or all below:
  - Consultation fee
  - Laboratory/Diagnostic Test
  - Medication
  - Hospitalization
  - Others (with specified medical items/services)

3. The preparation of payroll for the Medical Allowance shall be on a per school basis.

4. The School Administrative Officer II (AO II) shall be responsible for collecting and consolidating all accomplished Annex A and Annex B, including the required supporting attachments, from personnel in their respective schools.

5. The consolidated forms and supporting documents shall be submitted to this Office on or before March 17, 2026 for verification and further processing.

6. School Heads are directed to ensure the proper dissemination of this Memorandum and to provide the necessary assistance to personnel in the accomplishment of the required forms.

7. For information and guidance.



**Annex A**  
**Medical Allowance Registration 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 this activities.

**Section 1: Employee Information**

Full Name: \_\_\_\_\_  
Employee ID Number: \_\_\_\_\_  
Position/Designation: \_\_\_\_\_  
Office: \_\_\_\_\_  
Date of Appointment (dd/mm/yyyy): \_\_\_\_\_  
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: Form of Availment**

Kindly select one:

**Group**

\_\_\_\_\_ Agency Procurement

**Individual**

\_\_\_\_\_ Payroll Disbursement for availment of new/renewal of individual HMO

\_\_\_\_\_ Cash form for payment of medical expenses

**Section 3. Certification**

I hereby confirm that the information provided above is accurate and truthful. I agree to comply with the terms and conditions outlined in the Guidelines on the Grant of medical allowance to DepEd personnel, including the submission of required documents for verification and processing.

**Employee's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**Annex B**  
**Individual Cash Claim Form**

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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 this 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 HRMO denying the application



### Section 3. Details of Medical Expenses Incurred

Name of Medical Provider / Facility	Address	Date(s) of Medical Consultation / Service

Description of Expense	Amount (in Php)	Receipt No./Reference
Consultation Fee		
Laboratory / Diagnostic Tests		
Medication		
Hospitalization		
Others (pls specify)		
<b>Total Amount</b>		

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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