OFFICE MEMORANDUM
No. 46 s. 2026

IMPLEMENTATION AND IMMEDIATE PROCESSING OF THE MEDICAL ALLOWANCE FOR FISCAL YEAR 2026 IN DEPED REGIONAL OFFICE I

To: Assistant Regional Director
Chiefs of Functional Divisions
Heads of Units/Sections
All Concerned Personnel

1. This has reference to DepEd Order No. 16, s. 2025, titled "Guidelines on the Grant of Medical Allowance to the Department of Education Personnel," dated June 09, 2025.

2. To ensure the expeditious release of the Medical Allowance before the end of Quarter 1 of FY 2026, subject to the availability of funds, this Office is hereby authorized to process the release of the allowance through payroll disbursement, specifically under the two (2) individual availment options.

3. Personnel shall be guided by the following modes of individual availment:

3.1 **Individual Availment for availing of new/ renewal of HMO**

a. Upon receipt of the Medical Allowance, DepEd personnel may use the same for the availment of a new or the renewal of an existing HMO-type product.

b. The personnel concerned shall submit proof of enrollment with an HMO provider, which may include, but shall not be limited to any of the following:

i. copy of HMO agreement;
ii. valid Identification (ID) card issued by the HMO provider reflecting the name of the employee; or
iii. official receipt for the payment of the membership fee for the HMO product acquired.

c. In cases where the HMO-type product availed is below the rate of Php7,000 medical allowance, the personnel shall not be obliged to refund the excess amount.

3.2 **Individual Availment for payment of medical expenses**

a. DepEd personnel must secure any certification identifying them with any of the following conditions namely:

i. Their localities/ communities are identified as GIDA;

ii. Their localities/ communities have no adequate HMO branch or office of a licensed HMO company, as certified by the head of agency; or
iii. Their application in acquiring HMO coverage has been denied by an HMO company.

b. Upon issuance of the said certification, the concerned personnel may now be authorized to utilize the Medical Allowance for the payment of medical expenses, such as but not limited to hospitalization, emergency care, diagnostic tests, and medicines.

c. When the Medical Allowance is utilized for the payment of medical expenses, any amount incurred in excess of the Php7,000 shall not be subject to reimbursement by DepEd.

4. The following general guidelines shall be observed in the grant of Medical Allowance:

4.1 Personnel who are already in the service and who are expected to render at least a total or aggregate of six months of service within FY 2026 shall be eligible for Medical Allowance.

4.2 Newly hired personnel shall be eligible only after rendering six (6) months of services.

5. In this connection, the Administrative Division requests all eligible personnel to submit the duly accomplished and signed **Medical Allowance Registration Form (Annex A)** to the Personnel Section **on or before February 18, 2026**.

6. For those availing cash payment for medical expenses, Individual Cash Claim Form (Annex B) shall also be submitted, provided that all eligibility criteria specified in the guidelines are met.

7. Immediate dissemination of and strict compliance with this Memorandum are desired.

For the Regional Director:

ATTY. RHEA JOY L. CARBONELL
Chief Administrative Officer
Administrative Division

ADMIN/RJLC/roc/gnn/lgm/MedicalAllowanceFY2026
February 09, 2026

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 instated 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 (10) years for the effective implementation and management of its 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: _____ Email: _____

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 allowance

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 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 (10) years for the effective implementation and management of its 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: _____ Email: _____

Section 2: Pre-requisite Requirements
Supported with applicable documents, check any of the following conditions 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 Services
(please add rows as necessary)		

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

Please attach original receipts

Section 4: 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:** _____