**25 March 2026**

DIVISION MEMORANDUM
No. ___2 09___ s. 2026

PROJECT TIPA PRIORITY BENEFICIARIES BATCH 1

To: Assistant Schools Division Superintendent
Chief Education Supervisors
Heads, Private Elementary Schools
Heads, Unit/Section
All Others Concerned

1.   Pursuant to **DM 099 s. 2026** titled **Launching of PROJECT TIPA 2.0**, this Office announces the First Batch of Beneficiaries for PROJECT TIPA 2.0. Orientation of parents and beneficiaries will be on **March 27, 2026 at 8:30** in the morning at **Casa Del Nino Jesus De Tayabas, Brgy. Angustias Zone 2, Tayabas, City.**

2.   This activity aims to provide free eyeglasses to Listed Beneficiaries. Parents are advised to submit complete and accomplished documentary requirements (Enclosure 2 and 3).

3.   Please see Enclosure 1 for the List of Priority Beneficiaries, Enclosure 2 for Annex C (Claim Signature Form) and Enclosure 3 for Annex D (Claim Form Optometric Services).

4.   Immediate dissemination of this Memorandum is desired.
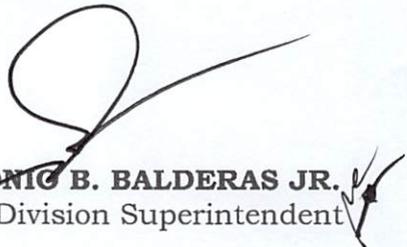
CELEDONIO B. BALDERAS JR.
Schools Division Superintendent

Encl.: As stated
Reference: DM 099 s. 2026
To be indicated in the Perpetual Index
under the following subjects:

TIPA BENEFICIARIES
EYE GLASSES

SGOD- project tipa priority beneficiaries' batch 1
SGOD17R4-004518/March 25, 2026

Enclosure 1: List of Priority Beneficiaries

NO.	NAMES OF STUDENTS
GRADE 1	
1	Sumilang, Aivhan Joshuel P.
2	Peñaflorida, Precious Hearth P.
3	Tayco, John Retsel
4	Balanay, Samara Sofia
5	Jeminez, Vaneloppe
6	Razalan, Kyrie Lucy
7	Abelido, John Michael
8	Dataro, Alberto
9	De Luna, Francine
10	Sumilang , Marianne Elisse
11	Guevarra, Maria Luntian
12	Zabella , Denzel
13	Gensoli,John Matthew E.
14	Cabuyao, Jacob Michael
15	Querubin, Matheo Zid E.
16	Manigbas, Gabrielle Therese R.
17	Parago, Diane Rose
18	Perez, Kiara Nathalie B.
19	Rico, Mary Sofia
20	Bequillo, Brave
21	Malana, Jaymark V.
22	Batalla, Gabrielle
23	Cablaida, Samantha Miracle
24	Cuballes, Jonnah Ashlyn N.
25	Reyes, Damille Khrysty
26	Cabuyao, Starzky Rein V.
27	Llema, Kheina Derielle C.
28	Mabuting, Zoe Amira C.
29	Quisanos, Shelley Tracy O.
30	Reyes, Zofia Cady P.
GRADE 6	
1	Marbella, Reymond Argete
2	Rivadenera, Zaimon Valenzuela
3	Caagbay, Jade Nathaly Maraig
4	Oliver, Sophia Mae Pinca
5	Tabi, Lianna Reyes
6	Tadiosa, Jiliane Saquedo
7	Cabuyao, Angelito Dylan Garcia
8	Mabilin, Arianna Kaitlyn Solano
9	Naynes, Jack Daniel Averilla

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10	Roxas, Zianley Rogel
11	Ybera, Carl Leonard Ortiz
12	Borhan, Jameelah Ayesha Pagana
13	Castillo, Ruthalla Euxine Salumbides
14	De Luna, Sibylla Lorien Manadan
15	Garcia, Johara Frinces Peralta
16	Pagana, Rhian Ghayle Guaño
17	Rosas, Kristine Joy Tabi
18	Trinidad, Princess Khate Labrada
19	Yema, Jaeden Rhaine Caalaman
20	Labitigan, Abis Hyralyn Jalbuena
21	Milla, Yckaj Aione Ardales
22	Quinto, Mikhaela Jaiden Javal
23	Escorpion, Kiel Ivan Rivera
24	Fernandez, Yvo Domitri De Chavez
25	Pabularcon, John Shairo Advincula
26	Casile, Erich Carmela Cuevas
27	Lagdameo, Janzen Zian Pineda
28	Alganes, Chrysthon Majed Potestades
29	Luna, Alden Jamil Oabel
30	Maaño, Eubert Rondola
31	Orias, Shalanie Sophia Reganion
32	Andanza, Francheska Mae Reyes
33	Limbo, Aia Kael Cajili

Enclosure 2: Annex C

PhilHealth
Your Partner in Health

Republic of the Philippines
PHILIPPINE HEALTHINSURANCECORPORATION
Citystate Centre 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 • Trunkline (02) 441-7444
www.philhealth.gov.ph
email: actioncenter@philhealth.gov.ph

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CSF
(Claim Signature Form)
Revised September 2018

IMPORTANT REMINDERS:
PLEASE WRITE IN CAPITAL LETTERS AND CHECK THE APPROPRIATE BOXES.
All information required in this form are necessary. Claim forms with incomplete information shall not be processed.
FALSE/INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.

Series #

PART I - MEMBER AND PATIENT INFORMATION AND CERTIFICATION

1. PhilHealth Identification Number (PIN) of Member:

2. Name of Member:
   Last Name | First Name | Name Extension (JR/SR/III) | Middle Name (ex. DELA CRUZ JUAN JR SPAG)

3. Member Date of Birth:
   month - day - year

4. PhilHealth Identification Number (PIN) of Dependent:

5. Name of Patient:
   Last Name | First Name | Name Extension (JR/SR/III) | Middle Name (ex. DELA CRUZ JUAN JR SPAG)

6. Relationship to Member:
   ☐ child ☐ parent ☐ spouse

7. Confinement Period:
   a. Date Admitted: month - day - year
   b. Date Discharged: month - day - year

8. Patient Date of Birth:
   month - day - year

9. CERTIFICATION OF MEMBER:
   Under the penalty of law, I attest that the information I provided in this form are true and accurate to the best of my knowledge.

   Signature Over Printed Name of Member
   Date Signed: month - day - year

   If member/representative is unable to write, put right thumbmark. Member/Representative should be assisted by an HCI representative. Check the appropriate box.
   ☐ Member ☐ Representative

   Signature Over Printed Name of Member's Representative
   Date Signed: month - day - year

   Relationship of the representative to the member
   ☐ Spouse ☐ Child ☐ Parent
   ☐ Siblings ☐ Others, Specify ___

   Reason for signing on behalf of the member
   ☐ Member is incapacitated
   ☐ Other reasons: ___

PART II - EMPLOYER'S CERTIFICATION (for employed members only)

1. PhilHealth Employer Number (PEN):

2. Contact No.: ___

3. Business Name: ___
   Business Name of Employer

4. CERTIFICATION OF EMPLOYER:
   "This is to certify that the required 3/6 monthly premium contributions plus at least 6 months contributions preceding the 3 months qualifying contributions with 12 month period prior to the first day of confinement (sufficient regularity) have been regularly remitted to PhilHealth. Moreover, the information supplied by the member or his/her representative on Part I are consistent with our available records."

   Signature Over Printed Name of Employer/Authorized Representative
   Official Capacity/Designation
   Date Signed: month - day - year

PART III - CONSENT TO ACCESS PATIENT RECORD/S

I hereby consent to the submission and examination of the patient's pertinent medical records for the purpose of verifying the veracity of this claim to effect efficient processing of benefit payment.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any legal liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

Signature Over Printed Name of Member/Patient/Authorized Representative
Date Signed: month - day - year

If member/representative is unable to write, put right thumbmark. Member/Representative should be assisted by an HCI representative. Check the appropriate box.
☐ Patient ☐ Representative

Relationship of the representative to the patient
☐ Spouse ☐ Child ☐ Parent
☐ Sibling ☐ Others, Specify ___

Reason for signing on behalf of the patient
☐ Patient is incapacitated
☐ Other reasons: ___

PART IV - HEALTH CARE PROFESSIONAL INFORMATION

Accreditation No.
Signature Over Printed Name
Date Signed: month - day - year

Accreditation No.
Signature Over Printed Name
Date Signed: month - day - year

Accreditation No.
Signature Over Printed Name
Date Signed: month - day - year

PART V - PROVIDER INFORMATION AND CERTIFICATION

1. PhilHealth Benefits: ICD 10 or RVS Code: 1. First Case Rate ___ 2. Second Case Rate ___
   I certify that services rendered were recorded in the patient's chart and health care institution records and that the herein information given are true and correct.

   Signature Over Printed Name of Authorized HCI Representative
   Official Capacity/Designation
   Date Signed: month - day - year

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Enclosure 3: Annex D

Annex D. Claim Form Optometric Services

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Series #

Part I - Member Information

1. PhilHealth Identification Number (PIN) of Member: ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

2. Name of Member:

| Last Name | First Name | Name Extension (JR/SR/III) | Middle Name (ex: DELA CRUZ JUAN JR SIPAG) |

3. Date of Birth: ☐☐ - ☐☐ - ☐☐☐☐
month / day / year

4. Mailing Address:

| Unit/Room No./Floor | Building Name | Lot/Blk/House/Bldg.No | Street | Subdivision/Village |

5. Sex: ☐ Male ☐ Female

| Barangay | City/Municipality | Province | Country | Zip Code |

6. Contact Information:

| Landline No. (Area Code + Tel. No.) | Mobile No. | Email Address |

7. Patient is the member? ☐ Yes, Proceed to Part III   ☐ No, Proceed to Part II

Part II – Patient/Client Information

1. PhilHealth Identification Number (PIN) of Dependent: ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

2. Name of Patient:

3. Date of Birth: ☐☐ - ☐☐ - ☐☐☐☐
month / day / year

| Last Name | First Name | Name Extension (JR/SR/III) | Middle Name (ex: DELA CRUZ JUAN JR SIPAG) |

4. Relationship to Member:
☐ Child
☐ Parent
☐ Spouse

5. Sex:
☐ Male
☐ Female

Part III – Health Care Institution/Facility (HCI) Information

1. PhilHealth Accreditation Number (PAN) of Health Care Institution: ☐☐☐☐☐☐☐☐☐☐☐

2. Name of Health Care Institution/Facility: _____

3. Address: _____

| Building Number and Street Name | City/Municipality | Province |

Part IV. Health Care Professional Information and Signature

1. Name of Professional Provider

| Last Name (ex: DELA CRUZ JUAN JR SIPAG) | First Name | Name Extension(JR/SR/III) | Middle Name |

Accreditation Number ☐☐☐☐☐ - ☐☐☐☐☐☐☐☐ - ☐

Signature _____
Signature Over Printed Name

Date Signed: ☐☐ - ☐☐ - ☐☐☐☐
month / day / year

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Part V Patient/Client Information on Service/s Availed

1. Was the patient/client referred by another Health Care Institution/Facility (HCI) ?

☐ No ☐ Yes

Name of HCI

PAN of Referring HCI |_|_|_|_|_|_|_|_|_|_|

Date of Referral |_|_| - |_|_| - |_|_|_|_|
Month   Day   Year

2. Was the patient/client referred by other institution?

☐ No ☐ Yes Name of Institution

Type of Institution

3. Date Provision of Service/s

|_|_| - |_|_| - |_|_|_|_|
month   day   year

4. Patient/Client Disposition

☐ a. Improved ☐ b. Recovered ☐ c. Discharged against medical advice ☐ d. Absconded
☐ e. transferred/referred to _____
Reason for referral/transfer _____

5. Working Diagnosis/es

6. Final Diagnosis/es   ICD 10 Code/s

7. Procedure/s Done   RVS/Package Code

8. Special Considerations

For Optometric Benefit Package (Details)

	S	C	AX	ADD	PD
OD					
OS					

9. PhilHealth Benefit Claim   RVS/ Package Code/s   1._____

Part VI Details of Copayment and Consent to Access Patient Records

1. Certification of No Copayment/Copayment

☐ No copayment ☐ with copayment   Amount of Copayment PHP _____

2. Details of Copayment

Total Charges (HCI and Professional Fees)	Mandatory Discounts (e.g., Senior Citizens, PWDs)	PhilHealth Benefit	Copayment
PHP	PHP	PHP	PHP

3. Consent to Access Patient Records

I hereby consent to the submission and examination of the patient's pertinent medical records for the purpose of verifying the veracity of this claim to effect efficient processing of benefit payment.
I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all legal liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

_____
Signature Over Printed Name of Member/Patient/Authorized Representative

Date Signed: |_|_| - |_|_| - |_|_|_|_|
month   day   year

PART VI Certification of Consumption of Health Care Institution/Facility

I certify that services rendered were recorded in the patient's chart and health care institution records and that the herein information given are true and correct.

_____
Signature Over Printed Name of Member/Patient/Authorized Representative

Date Signed: |_|_| - |_|_| - |_|_|_|_|
month   day   year

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