Republic of the Philippines
Department of Education
REGION IV- A CALABARZON
CITY SCHOOLS DIVISION OF THE CITY OF TAYABAS

01 June 2026

DIVISION MEMORANDUM
No. 367 s. 2026

EYE GLASSES TURNOVER OF THE PROJECT TIPA PRIORITY BENEFICIARIES BATCH 1

To: Assistant Schools Division Superintendent
Chief Education Supervisors
Heads, Public Elementary and Secondary 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 **Eye Glasses Turnover of the First Batch of Beneficiaries for PROJECT TIPA 2.0** on **June 1, 2026 at 1:30** in the afternoon at **Cipriano J. Querubin Elementary School, Brgy. Wakas, Tayabas City.**

2. This activity aims to provide free eyeglasses to the listed beneficiaries. Parents and guardians are expected to accompany their children when claiming the eyeglasses.

3. Submission of complete and accomplished documentary requirements is necessary to process the eye glasses (Enclosure 3 and 4).

4. Please see **Enclosure 1 for the Turn Over Program, Enclosure 2 for the List of Priority Beneficiaries, Enclosure 3 for Annex C** (Claim Signature Form) and **Enclosure 4 for Annex D** (Claim Form Optometric Services).

5. Immediate dissemination of this Memorandum is desired.

CELEDONIO B. BALDERAS JR.
Schools Division Superintendent

Encl.: As stated
Reference: RA 9155 s. 2001, RA 8525 s. 1998
RA 1158 s. 2019
To be indicated in the Perpetual Index
under the following subjects:

ADOPT-A-SCHOOL
LEARNER
TURN OVER

SGOD- eye glasses turnover of the project tipa priority beneficiaries' batch 1
SGORJ5FJ-004901/June 01, 2026

Enclosure 1: Turnover Program

Eye Glasses Turnover of The Project Tipa Priority Beneficiaries Batch 1
Cipriano J. Querubin Elementary School
June 1, 2026
1:30 a.m.

ACTIVITY	FACILITATORS / PRESENTERS
Program Launching	
Nationalistic Song Prayer	AVP
CALABARZON March Division of Tayabas City March	
Welcome Remarks	**ARLENE D. PAGANA** School Head – CJQES
Acknowledgement of Participants	**IMELDA C. RAYMUNDO** CES – SGOD
Inspirational Message	**HERBERT D. PEREZ, CESO VI** Assistant Schools Division Superintendent
Presentation: PROJECT TIPA Overview and Accomplishments	**JOAN KATHLEEN M. TALABONG** EPS II
Formal Turn - Over of EYE GLASSES	**CELEDONIO B. BALDERAS JR.** Schools Division Superintendent **ARLENE D. PAGANA** School Head – Masin Elementary School **DRA. CRISEL CORTEZ – GARCIA** IPAO – Quezon
Deed of Donation and Acceptance Signing	**SDO Officials and Partners**
Word of Thanks	**Tayabas City PTA Federation President** **Parent Beneficiaries**
Message of Support and Commitment	**SDO Partners**
Photo Opportunity	
Katrena Obis Mistress of Ceremony	

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

Address: Brgy. Potol, Tayabas City
Telephone No.: (042) 785-9615
Email Address: tayabas.city@deped.gov.ph
Website: https://www.sdotayabascity.ph

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
NOTHING FOLLOWS	

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Enclosure 3: Annex C

PhilHealth

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PHILIPPINE HEALTHINSURANCECORPORATION
Citystate Centre 709 Shaw Boulevard, PasigCity
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 SIPAG)
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 SIPAG)
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

Signature Over Printed Name of Member's 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.
☐ Member ☐ Representative

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 memebers 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 within 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)
☐☐☐☐-☐☐☐☐☐☐☐-☐		
☐☐☐☐-☐☐☐☐☐☐☐-☐		
☐☐☐☐-☐☐☐☐☐☐☐-☐		

PART V - PROVIDER INFORMATION AND CERTIFICATION

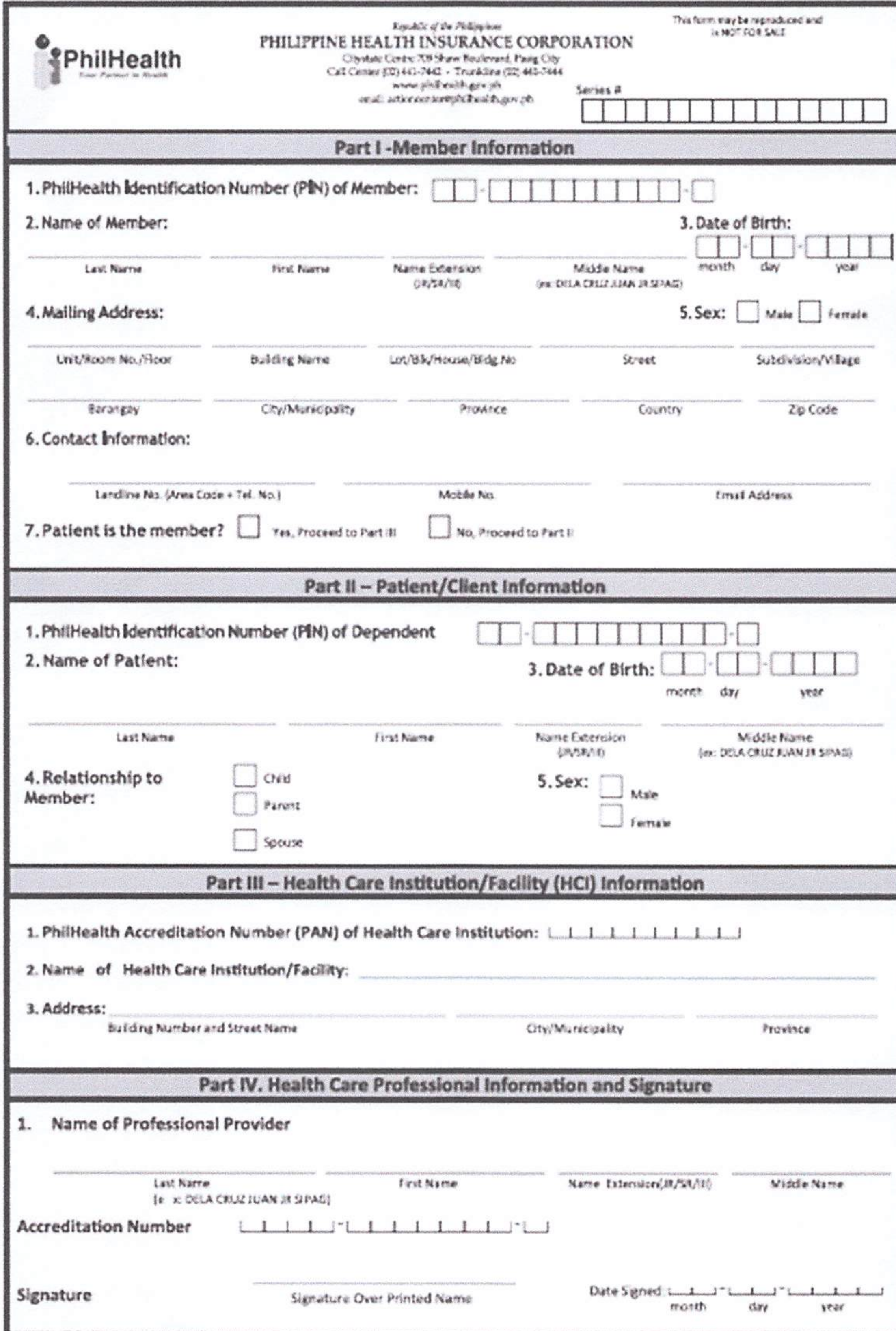
1. PhilHealth Benefits: ICD 10 or RVS Code: 1. First Case Rate ______ 2. Second Case Rate ______

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

Enclosure 4: Annex D

Annex D. Claim Form Optometric Services



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email: actioncenter@philhealth.gov.ph

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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

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

5. Sex: ☐ Male ☐ Female

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

Page 1 of 3 of Annex D

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)

Page 2 of 3 of Annex D