New Hampshire
Department of
Revenue Administration

DP-153-ACH
Medicaid Enhancement Tax Authorization Agreement for Electronic Payments

◯ ACH Debit **OR** ◯ Wire Transfer

Per Rev 2505.05 This form shall be filed at least 3 business days prior to the due date of the tax payment to allow for processing time.

STEP 1 HOSPITAL NAME & ADDRESS

HOSPITAL NAME	TAXPAYER IDENTIFICATION NUMBER
NUMBER AND STREET ADDRESS	
ADDRESS (continued)	
CITY/TOWN STATE & ZIP CODE+4	

STEP 2 FINANCIAL INSTITUTION INFORMATION

FINANCIAL INSTITUTION (BANK) INFORMATION

Financial Institution Name	Financial Institution Routing & Transit #
Name on Financial Institution Account	FEIN/SSN on Financial Institution Account
Financial Institution Account Number	Account Type (check one) ☐ Savings ☐ Checking

STEP 3 ACH DEBIT AUTHORIZATION

Authorized Amount of ACH Debit ..... $

This authorization is applicable to the FY 2019 Medicaid Enhancement Tax liability. By signing below, I hereby authorize the State of New Hampshire Treasury to initiate a debit entry to the bank account and the financial institution (bank) named above, on or before April 15, 2019.

SIGNATURE (IN INK) OF AUTHORIZED OFFICER/REPRESENTATIVE

E-MAIL ADDRESS

TELEPHONE NUMBER

PRINT SIGNATORY NAME & TITLE

DATE

STEP 4 WIRE TRANSFER AUTHORIZATION

Authorized Amount of Wire Transfer ..... $

This authorization is applicable to the FY 2019 Medicaid Enhancement Tax liability. By signing below, I hereby acknowledge that payment will be wire transferred to the State of New Hampshire Treasury from the financial institution (bank) named above, on or before April 15, 2019.

SIGNATURE (IN INK) OF AUTHORIZED OFFICER/REPRESENTATIVE

E-MAIL ADDRESS

TELEPHONE NUMBER

PRINT SIGNATORY NAME & TITLE

DATE

MAIL TO:
NH DRA
ADMINISTRATION UNIT
PO BOX 457
CONCORD, NH 03302-0457

FOR DRA USE ONLY